October 1960

Mental Hospitals

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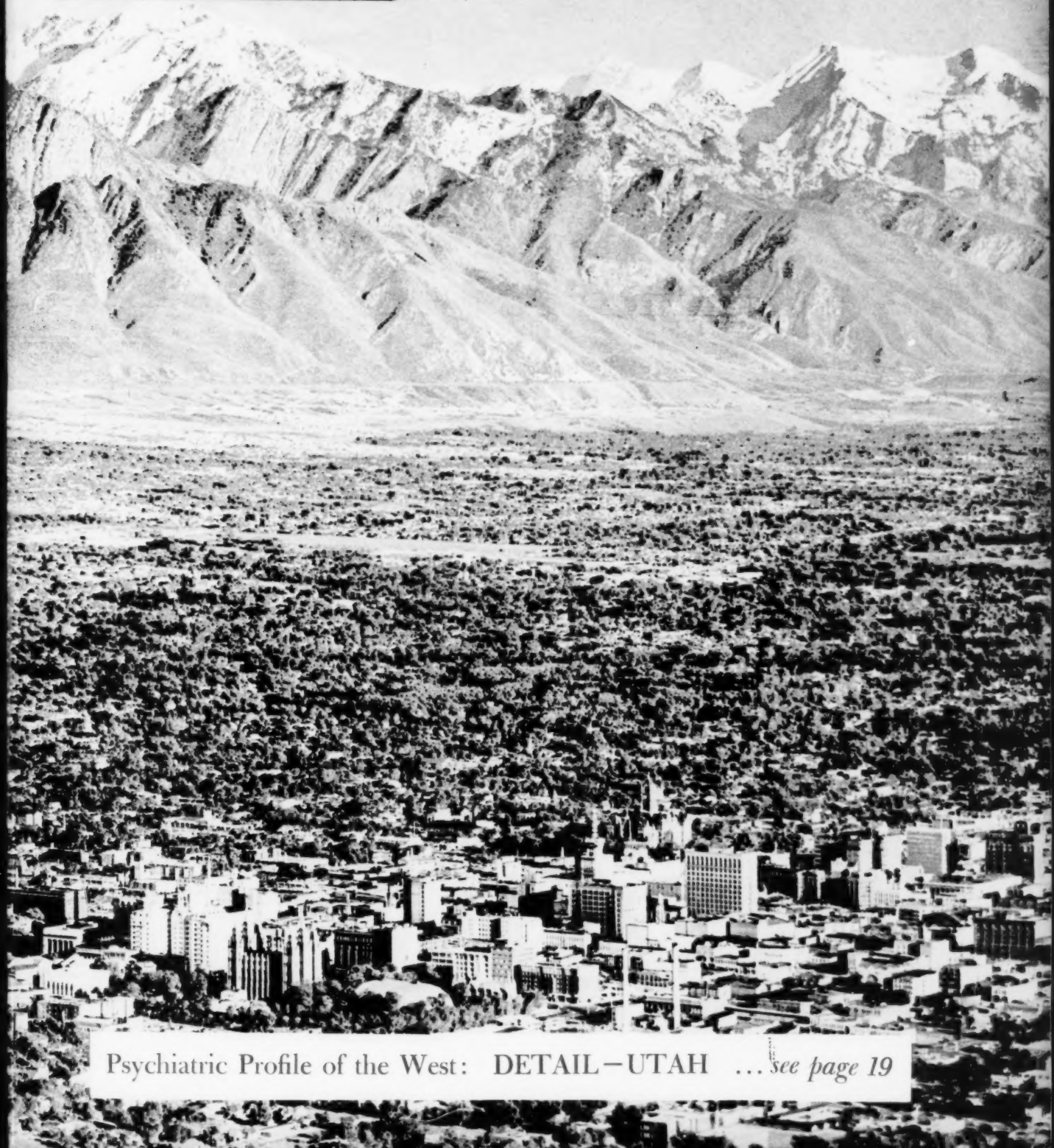

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Personal communications to the Division of Clinical Research from: (1) Sidney Cohen, M.D., Chairman, Research Committee Neuropsychiatric Hospital, Veterans Administration Center, Los Angeles 25, California. (2) Danville (Pennsylvania) State Hospital, study in progress. (3) Eastern State Hospital, Vinita, Oklahoma, Clinical Director G. W. Kleinschmidt, M.D.; experimental work conducted by Attila Nagy, M.D. (4) Hamilton, M.; Smith, A. L. G.; Lapidus, H. E., and Cadogan, E. P.: A Controlled Trial of Thiopropazate Dihydrochloride (Dartalan), Chlorpromazine and Occupational Therapy in Chronic Schizophrenics, J. Ment. Sc. 106:40 (Jan.) 1960. (5) Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 6. Edisen, C. B., and Samuels, A. S.: Arch. Neurol. & Psychiat. *80*: 481 (Oct.) 1958.

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MENTAL HOSPITALS offers a forum for free discussion about matters of interest to persons involved in the care and treatment of psychiatric patients. Opinions expressed by the authors are theirs and do not necessarily represent the official policy of the American Psychiatric Association.

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*Livingston, S., and Petersen, D.: New England J. Med. 254:327 (Feb. 16) 1956.

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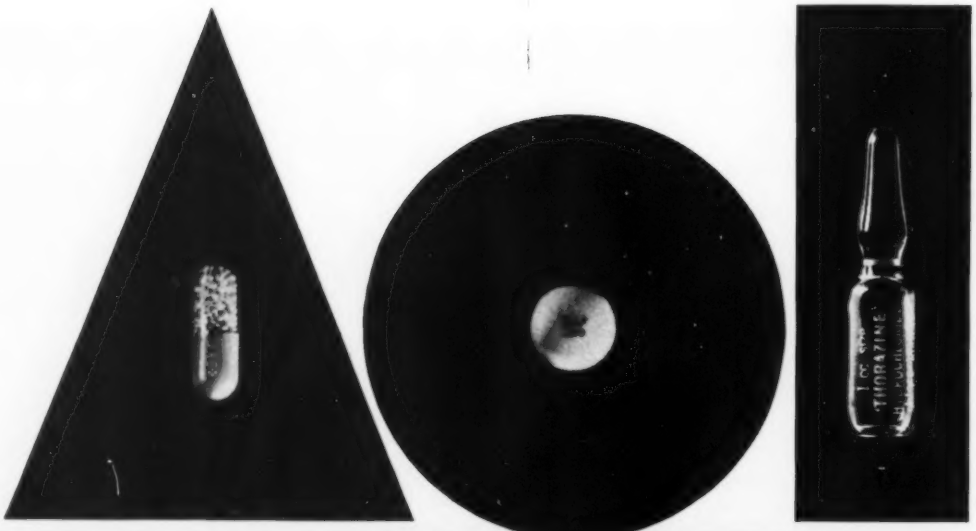

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BUILDING A MENTALLY HEALTHY COMMUNITY

By ADDISON M. DUVAL, M.D.
Director, Division of Mental Diseases
Department of Public Health and Welfare
Jefferson City, Missouri

TODAY WHEN WE SPEAK of mental health we mean much more than simply absence of illness. To be mentally healthy means to be happy; to have peace of mind, harmony of desires and successes, resilience to life's tough problems; to love and to be loved—all in the presence of a supporting personal philosophy.

During the past year I presented to the Kansas City Mental Health Association sixteen basic guides to the development of state mental health programs. Included were guidelines specifically directed to community planning. These are as follows:

1. Improved community psychiatric services will reduce the number of admissions to state hospitals.
2. All-purpose psychiatric clinics are necessary in a modern program. These should include the functions of pre- and post-hospital psychiatric services.
3. Day- and night-hospitals, family care, and nursing homes should be helpful in the total program.
4. All general hospitals should have some responsibility for psychiatric community services.
5. Community consultative psychiatric services should be provided to juvenile and adult courts, public schools, welfare and recreational departments, nursing homes, jails, and prisons.
6. Hospital prepayment and insurance plans should include provisions for psychiatric illness.
7. Failure to provide humane care and enlightened treatment to mentally ill citizens tends to weaken the moral fibre of our whole nation.

I would like to probe into some other less well-defined areas which a Community Planning Council concerned with mental health must not overlook. These areas are still largely within clinical treatment frontiers, but close to the fringes, and they overlap specific areas of prevention.

In speaking of psychiatric treatment services, Gruenberg[1] has said, "While each of these services has been of value, none of them alone, nor even all together, will produce a reduction in the size of the mental health problem in a community unless they devote themselves to activities that will actually improve the mental health of the people." In other words, we must first identify those aspects of living which strengthen, and those which weaken the mental health of our citizens. Once these are identified, a public health prevention program can reduce the incidence of mental disease and deficiency just as it has that of physical diseases. While we do not yet have full knowledge of the identity of all the positive and negative elements of daily living, we do have a limited knowledge which can be utilized helpfully. By strengthening the positive aspects and reducing the negative, we get to the heart-core of prevention of mental illness and mental deficiency.

WHERE DO WE STAND?

The established public health method to be applied includes (1) preventing what can be prevented, (2) treating illness by all known helpful methods, and (3) reducing the disability associated with illness where this can be reduced. Where does psychiatry stand today in the application of this method?

Are we, for instance, applying all our knowledge to prevent brain damage to the newborn? Are our maternal and child health services giving close attention to this problem? We know that death rates for both mother and child have been sharply reduced in recent years, but have we given attention to the resulting increase in the numbers of mentally retarded, palsied, blind, deaf, epileptic, and other handicapped children who live be-

Ed. Note: This article is based on a paper presented at the 1960 annual meeting of the Community Planning Council of St. Joseph, Missouri.

cause of this reduced death rate? Are these handicaps preventable? Some certainly appear to be, while others are partially so. Specifically, we are referring to such defects as those caused by congenital syphilis, by the Rh incompatibility of the parents' blood, and by German measles in the mother during pregnancy. These defects are essentially preventable, if adequate examinations of the mother are always made. At present, we suspect but do not know the extent of damage caused to the unborn child by poor nutrition in the mother. We do know the devastating effects on the child of severe reduction of the oxygen supply in the mother's blood for one reason or another. We do not yet know the effects of a small reduction of oxygen, which might be a complication of infectious diseases, toxic states, alcoholism, thyroid deficiency, or the ingestion of certain drugs. Nor do we yet know what, if any, damage to the child results from regular moderate doses or single large doses of the so-called tranquilizing drugs to the expectant mother. More research is needed before proper conclusions can be reached.

Norris[2] reviews the prenatal factors in mental development, emphasizing the importance of the first twelve weeks of the human fetus. He points to the higher incidence of mental retardation in children conceived in June as related to those conceived in December, hypothesizing that this may be due to decreased protein intake during the summer. Complications of pregnancy in the mother—whether physical or emotional—appear to be related to an increased incidence of mental retardation, cerebral palsy, epilepsy, and behavior disorders in the child. Further research may indicate that the obstetrician has an important role to play in the prevention of mental defects in the newborn, and consequently, of emotional disturbance in the family.

HEALTH AND WELFARE PROBLEMS

With regard to alcoholism, we now know that delirium tremens is essentially preventable by the ingestion of a balanced diet, but this knowledge is not yet put to full use. We also know that proper nutrition is an important element in sustaining the mental and physical health of our aging citizens. Are our social agencies and the general public giving adequate attention to this basic requirement in their assignment of monetary aid to our older indigent citizens? Let us remember, too, that an adequate diet is no good without teeth which can masticate. Today we have the greatest surplus of food in our nation's history. Yet many of our people are still clinically undernourished or suffering from unbalanced nutrition. This becomes more important as the average span of life is extended. We are becoming an older citizenry. With lengthened life come additional health and welfare problems which need careful long-range planning.

Are we paying enough attention to the strengthening of family life in our society? The Gluecks[3] have shown us that juvenile delinquency can be accurately predicted by looking at five elements in family life. These elements are (1) discipline by the father, (2) supervision by the mother, (3) affection by the mother, (4) affection by the father, and (5) unity of the family as a group. Have these elements been ignored in our search for better community mental health? We know that many children really have no family life. Large numbers are now awaiting home placement, yet no homes are available. The incidence of mental illness increases in children without proper family relationships. Yet the placement of children in unstable foster homes may be worse than no placement at all. We should also search constantly for ways and means to strengthen the character, motivation, and maturity of our growing youth. One way is to live as individual parents and enlightened citizens so that our children—through identification with us—strive to be like us. Our weaknesses can rise up to strike down our children during their formative development.

EDUCATING THE MENTALLY DISABLED

Do we remove a mentally ill or retarded child from the public school too quickly? Obviously the common good of other children in the classroom must be carefully considered, as well as that of the disabled child, but we know that a mentally disabled child excluded from school is in a more hazardous position than one not excluded. We might, therefore, give more attention to devising better ways and means of keeping moderately disabled children in public schools by providing enough specially trained teachers and consultation in psychiatry or psychology if needed. Communities might use other approaches to positive mental health by encouraging, for instance, more church-centered family activity, and more individual participation in politics and government; by improving police methods, especially for juveniles; by improving living standards; and by working closer with youth groups themselves in planning for them.

The community's attention should also be directed to the inadequate operation of adult and juvenile courts, and particularly to their need for the help of professional people. At present, mental illnesses or defects in persons coming before the court often pass undetected. It has been estimated that 10 per cent of those in jails and prisons are mentally ill! In Massachusetts the law calls for a mental examination of all individuals charged with major crime, who have a record of previous convictions. Similar laws in other states would help to identify those who are mentally ill.

CRIMINAL RESPONSIBILITY

Most states need to re-examine their tests for criminal responsibility in the light of new knowledge gained from the fields of psychology and psychiatry about human behavior. Most psychiatrists believe the old McNaghten Rule—i.e., knowledge of right and wrong—is no longer an adequate test of criminal responsibility. The psychiatrist, however, should not be asked to judge whether the presence of mental illness—mild or severe—constitutes "insanity" or "unsoundness of mind" before the court. As a physician, he should clearly report his findings of illness, if any, together with his opinion on

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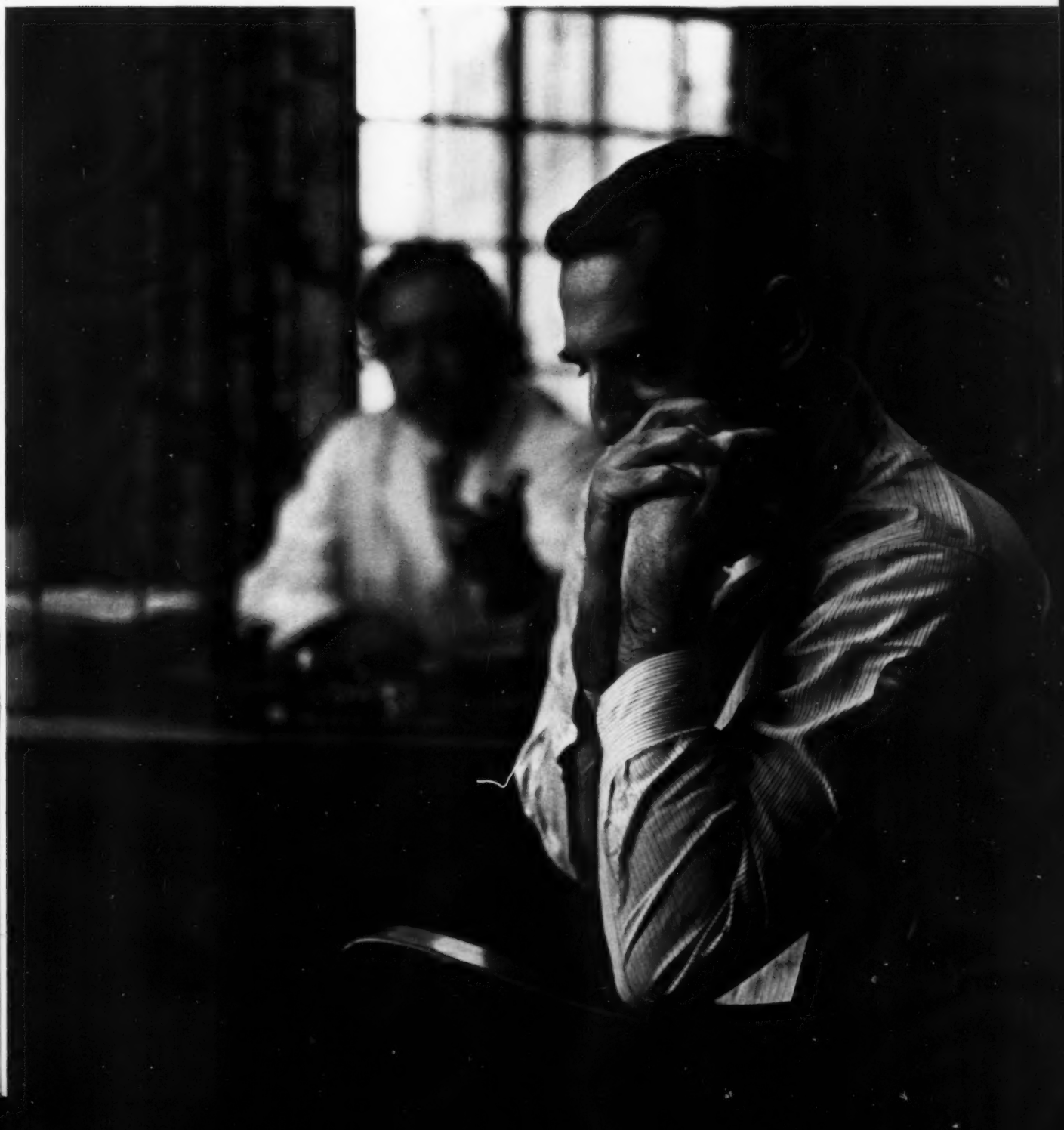

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References: (1) Ayd, F. J., Jr.: New England J. Med. *261*:172, 1959. (2) Morgan, D. R., and van Leent, J. P.: M. J. Australia *45*:696, 1958.

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the relationship of the illness to the crime committed. In a democracy, however, it is the duty of the court and/or the jury to decide whether the individual is criminally responsible and whether he should be sent to a mental hospital. The psychiatrist cannot be prosecutor, witness, judge, and jury all in one. Such would be a travesty of justice.

It would be a great step toward positive mental health if the community could accept mental illness—whether mild or severe—without undue anxiety, prejudice, or distortion. Inability to do this is obstructing the best-intentioned rehabilitation plans for discharged patients. Somehow we have failed to share our modern knowledge about mental illness, including its specific causes, treatments, and recoverability. Too many people still believe that once mentally ill, always mentally ill, and that each mentally ill person is always actively dangerous. This is simply not true. Our citizens are impressed by newspaper reports of crime committed by former mental patients. What they fail to realize is that, according to reliable statistics, the discharged state mental hospital patient breaks the law less frequently than the citizen who has never been mentally ill. This misunderstanding is furthered by the fact that the good adjustments made by most discharged mental patients are not considered to be news.

SOCIAL RELATIONSHIPS

A healthy family is composed of healthy individuals, and a healthy community is made up of healthy families; but just as the individual is more than the sum total of his body organs, so is the total community more than the sum of its component families. Just as we consider the relationships between the functions of the different body organs, so must we recognize the importance of the interrelationships between segments of the community—be these racial, religious, or social. Modern sociology is bringing new and helpful insights into these aspects of community life, but we need a great deal more research to develop and point the way to future planning.

Communities may be said to operate much like individuals with regard to two broad aspects of personality—body and spirit. Body is represented by homes, streets, stores, schools, and churches, while spirit is expressed in goals, feelings, mores, and attitudes. The healthy community, like the healthy individual, can be described as enjoying reasonable security, good status in relation to others, the consummation of loving others and being loved, the satisfaction of active and passive recreation—all in the presence of a satisfying philosophy.

More insight might be gained into the operations of a community if we applied to it our available knowledge about human personality—its needs, structure, function, and defects. We see a great variety of functions within the average person, all without the presence of disease. The same concept applies to communities, and there is a great similarity in basic needs.

The same type of comparison could be made with regard to the development of anxiety and tension in the individual and in the community, and also to the methods by which these are properly controlled in either case. Other relationships are seen in such areas as discipline, education, isolation, integration of value systems, communication, prejudice, and various other social adjustments.

Mackay[4] has said that the "great trouble with the world lies in the perversity and contrariety of human behavior. Perversities arise, not from intellectual, but from emotional forces in the individual. Virtue is not born of knowledge, nor vice of ignorance. The determinative emotional forces in behavior are compounded out of the original self-preservative and race-preservative impulses of the individual. If they are deformed into patterns of fear and hatred and aggression, it is not in formal education, but in the complex personal impact of parent and society on the child."

RESEARCH AND NEW KNOWLEDGE

If we believe these statements, it behooves us, as community planners, to push forward on all fronts—not only to improve and refine present knowledge concerning man and his social actions, but to develop through intensive research new knowledge and new methods which can guide us along the path to better mental health for individuals, for families, and for communities.

If clinical psychiatry is to be of material assistance in improving the mental health of our communities, I believe we must be willing to move away from purely institutional psychiatry and directly into intimate participation with other social agencies in an attempt to determine what disease-producing forces are and how they are identified. One way to do this is to study carefully the crisis situations in families and in individuals to determine why and how these situations are worked through successfully or unsuccessfully. We need to know why maladaptive mechanisms develop, and why these sometimes result in mental disease and sometimes do not. Only through such increase of knowledge will the answers be found.

For the development of a whole stream of dynamic forces moving toward positive mental health, we need the intense and very personal interest and support of every organization, agency, club, association, society, and congregation which makes up the community, as well as the interest of dedicated individuals. Only in this way will our objective of improved mental health for the individual, for the family, and for the community be possible in the years to come.

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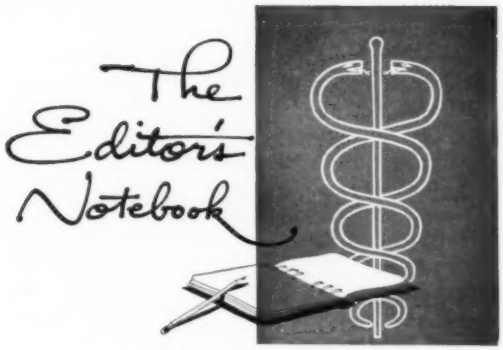

A RECENT LETTER from Dr. Harold L. McPheeters, Secretary-Treasurer of the National Association of State Mental Health Program Directors, commented upon the undesirability of changing the name of this magazine from MENTAL HOSPITALS to something which might imply a broader coverage of current psychiatric practices. Dr. McPheeters, in reporting upon the discussion held by his organization in Atlantic City last May, writes in part:

"The overwhelming sentiment favored retaining the name MENTAL HOSPITALS and keeping the primary focus on mental hospital activities. There was general acknowledgment that the hospitals will be moving much closer to communities, and that this aspect of the mental hospital role should be featured in the magazine. . . . The members felt the need for one journal dealing specifically with the mental hospital and its activities."

These leaders of the state mental health programs have thus pinpointed a trend which is almost daily gathering momentum—joint endeavor by hospitals and communities. Dr. Addison M. Duval's article "Building a Mentally Healthy Community" (see page 7) represents a milestone in thinking. Here is a state commissioner concerning himself with matters which, a few years ago, would have seemed quite outside his purview. Dr. Harry Solomon (page 14) in his Past President's essay, points out that ideas which only three years ago were barely experimental are today the subject of a 1960 report to the Governor of a great state.

In the 1940's, as Mr. Mike Gorman reminds us (p. 24), we were concerned with rescuing the state mental hospitals from their sad plight, in doing something about "the shame of the states," "cleaning up the snakepits," and so on. We promised all kinds of wonderful things if only we could have more hospital beds, more intensive treatment units, more buildings. Much was needed, and indeed much was accomplished during these years.

Then came Dr. William Menninger's famous words "brains not bricks," followed in 1958 by Dr. Solomon's much misunderstood suggestion that large mental hospitals should be liquidated. (The operative word "large" was the one which was overlooked by his critics!)

Today, however, we have shifted away from the notion that "community psychiatry" is somehow opposed to "hospital psychiatry." At the 1960 Mental Hospital Institute, to be held October 17-20 in Salt Lake City, nearly 500 hospital people will explore in depth their relationships with various community groups. By implication, we are beginning to regard the mentally sick as "people" rather than as "patients."

But we must not turn our backs on what has been useful in the past. In our enthusiasm for new ideas, we must not overlook the place of the public mental hospital in the continuous treatment chain. Not all patients can be discharged—at least in our present state of knowledge. As Dr. Solomon points out, state mental hospitals will continue to be needed for those whom we do not yet know how to restore to health. This courageous man accuses us all, including himself, of neglecting our duty to study the problems presented by these so-called "chronic patients."

Let us by all means continue to broaden the treatment field of public mental hospitals, and at the same time, the editorial content of our magazine. This is the trend—this is history in the making. But just as we shall continue to strive for the betterment of the "hard core" of long-term patients, so will our magazine continue to publish papers on "inside-hospital" problems.

The name MENTAL HOSPITALS is not outworn, nor have its subscribing hospitals outworn their usefulness. Outworn only is the notion that a hospital is a permanent "city of the sick" bounded by the bricks and mortar of its walls, and by the real estate on which it stands.

Matthew Ross, M.D.

Number Two in a Series by Past Presidents of A. P. A.

HOSPITAL PSYCHIATRY TODAY

By HARRY C. SOLOMON, M.D. (1957-1958)

Commissioner,
Massachusetts Department of Mental Health, Boston

When Dr. Mathew Ross, the Medical Director of the A.P.A., and the Editor of Mental Hospitals, asked me to write an essay in my role as Past-President, I re-read the Presidential Address I gave in 1958 to the membership of the A.P.A. Among other things, I said:

"We are now in a period of hopeful change . . . in treatment facilities for the mentally ill. Psychiatric wards are being opened in the general hospitals; outpatient clinics are increasing in numbers; day- and night-hospital facilities are being provided: half-way houses are being experimented with; the place of an extension service whereby the hospital provides service to patients living at home is being studied on models provided by our English colleagues . . . Liberalization of insurance plans to provide care for mentally ill individuals makes possible greater utilization of wards in general hospitals and private mental institutions. Small intensive treatment units are being provided either as independent hospitals, or as a portion of the large hospital providing a more rapid turnover of patients. Rehabilitation services and aftercare clinics help to support patients in the community who previously would linger in hospitals. An atmosphere of greater optimism about the outcome of psychoses leads to an attitude of greater liberalization in the discharge of patients and a willingness on the part of hospital authorities to take certain calculated risks. Several states are experimenting with new types of facilities to better comfort those among our aged people who show some signs of mental deterioration but who are not disturbed enough to find the wards of our mental hospitals a suitable haven. All of these factors have favorable potential for reducing the number of chronic patients and lessening the need for beds."

I also expressed the belief that the care of the long-term mentally ill patient, who will be with us for a considerable period of time, remains as one of the great challenges we have failed to meet and must somehow attack anew. I repeat today, with total conviction, that this challenge demands much study, much investigation, and a concentrated effort to do our duty. For these chronic patients, our present hospitals will continue to be needed, although we may confidently expect that, following the trend of recent years, the number of patients in public mental hospitals will be greatly reduced.

In discussing the evolution of the large public mental hospital as we now know it, I further stated that we could not expect much improvement in the staffing of these institutions, and that, therefore, we could not expect to make true hospitals out of them. No state hospital even today has an adequate staff as measured against the *minimum* standards set by the American Psychiatric Association, yet these standards represent only a compromise between what was thought to be truly adequate and what might be remotely possible.

Today, three years later, the A.P.A. has developed a proposal to conduct a study leading to the reformulation of the existing standards. (Ment. Hosp. 11:5:37-38, May 1960.) Among a number of criticisms made was the statement that existing standards "do not provide a basis for speeding the development and applicability of new and promising trends and practices."

THE THERAPEUTIC COMMUNITY

The standards were developed at a time when all our attention was concentrated upon improving our existing facilities – public institutions housing many thousands of patients. At this time, humane care was foremost in our minds, and until the minimal necessities for shelter and subsistence were obtained, we were not able to think of dynamic treatment programs. During the past decade, however, we have seen the birth of the so-called therapeutic community, with its emphasis on interpersonal relationships and patient self-help. This concept leads naturally to a consideration of whether all acutely ill patients need stay in the hospital so long that they develop what might be termed a side-effect–"institutionalization." These ideas have been greatly facilitated by the new ataractic drugs which came into extensive use in the middle of the 1950's.

It was within this context that I addressed my colleagues at the Annual Meeting of 1958. Now, in 1960, my report as Commissioner of Mental Health, to the Governor and Legislature of the Commonwealth of Mas-

sachusetts represents my own proposals, and those of the Department of Mental Health, as to how we may continue to develop these ideas into a truly modern program for the treatment and prevention of mental illness. What follows is, in essence, the heart of this report.

During the past four years, Massachusetts, like almost every other state, has been able to report a reduction in the number of individuals remaining in its public mental hospitals at the end of each year. This trend towards the depopulation of state hospitals means that a greater number of patients are being returned to their homes and their communities, most of them capable of productive services to these communities. Yet during the same period, there has been a notable increase in the number of admissions. Whereas the number of patients remaining in Massachusetts hospitals shows a decrease of an estimated 2.6 per cent, the total admissions have risen by 30 per cent.

RISING COSTS

Obviously, then, we are able to treat a larger number of patients and restore them to their communities in a comparatively short period of time. A pertinent question is whether, as a result, the expenditures will be reduced. On the contrary, a reasonable projection of future needs and plans to meet these needs indicates an *increase* in costs. In 1950, the costs of the Massachusetts Department of Mental Health amounted to over thirty million dollars. The projected figure for 1960 is nearly sixty-million—practically double the amount a decade ago.

Some of this increase, of course, reflects inflation, increases in wages, and improved facilities. The cost of medical care has risen precipitously throughout the country, and state hospitals are subject to similar increases.

There are other causes, however, and one of these, curiously enough, is shorter hospitalization. In Massachusetts, we admit about 11,000 patients to our institutions annually—and at the same time we must deal with some 20,000 anguished relatives, who must be interviewed and given supportive treatment. The newly admitted patient requires much more than the long-term patient in the way of intensive care, professional services, laboratory studies, X-ray services, and the like.

Thus, with the increasing admission rate and shorter hospital stay, costs are greatly increased, and the forecast is for a continuing accelerated admission rate over the next few years. This is because the great increase in births during the last 15 years or more is now producing individuals who are in the period of life most prone to mental breakdown.

In order to facilitate the discharge of hospitalized mental patients, conditions must be provided for community readjustment. More psychiatric social workers are desperately needed to keep pace with the discharge rate. Rehabilitation personnel, now nonexistent in most institutions, are greatly needed. More recreational workers and occupational therapists are required to activate patients and fit them for life outside the hospital. Public relations personnel would help to provide a more positive climate in the home community. With the large number of employees in our institutions, personnel officers should be available, but at present seldom are.

Aftercare of discharged patients is essential if continuing health is to be expected and re-admission to the hospital avoided. Mental disease, by and large, tends to be of a chronic nature; thus, continuing treatment and support is needed for many patients over a long period of time. If this is not available, hospitalization must be prolonged, or in many cases, re-entry becomes necessary. It is curious that of all types of chronic illness, mental illness is the only one for which little or no provision has been made for continuing care and treatment.

At the same time, facilities must be provided for pre-hospital treatment, and for screening of patients so that only those who are in true need of hospitalization will be admitted. Two important experimental projects are being carried out in this area by the Boston State Hospital and the Massachusetts Mental Health Center. These studies have shown that about 50 per cent of the patients being considered for hospital admission can be cared for in the community without total hospitalization. At the Boston State Hospital a team is available at all hours to meet acute emergencies by going to the home of the individual, examining him, and assessing the type of care and treatment which might best suit his needs. At the Mental Health Center, which is a smaller institution with a waiting list of patients for whom there are no beds, emergency cases are referred to the Community Extension Service (Ment. Hosp. 11:6:36-38, June 1960) where a similar assessment of needs is made.

Day-hospitals are among the alternatives which are meeting with considerable success. It is possible for some patients applying for full admission to use these part-time facilities instead. They thus avoid the disadvantages of total hospitalization and remain in the midst of their families and communities. A side-result is that the medical costs are much reduced. Again, the availability of the day-hospital allows for an earlier release from the hospital of a considerable number of patients, who can thus have limited care before again taking on the total responsibilities of living.

COMMUNITY CLINICS

In Massachusetts we have developed some 18 clinics in different communities. Each local community contributes to the administrative costs of its own clinic and furnishes housing, while the Division of Mental Hygiene supplies a professional clinical team. At present these clinics are devoted primarily and almost exclusively to the diagnosis and treatment of disturbed children up to the age of sixteen. Another enterprise of this division, undertaken in 1957, is the establishment of pre-school nursery centers for retarded children between the ages of three and seven. At the present time some 24 centers are functioning. Although the existing 18 clinics and 24 centers are still insufficient in number, they do provide a striking example of what can be done to help individuals through their difficulties without resort to a hospital or institution.

Among the activities of the Department of Mental Health is the Division of Legal Medicine which attempts

to provide psychiatric services to delinquents, to prisoners at the correctional institutions, to parolees, to the Youth Service Board and to the courts. Clinics afford examinations and reports to the courts and probation services, and make treatment available to individuals who authorities feel would benefit from it. Under our existing laws any court may send individuals appearing before it to a state hospital for examination and report, but this is expensive and perhaps undesirable in some cases. In areas where the Division of Legal Medicine has a clinic, the references to the hospitals are reduced by about 50 per cent, with the great advantage of quicker service to the court at less cost to taxpayers.

Research activities, too, are costly, but it is generally recognized that benefits to all patients are greatly enhanced by the existence of a research program in a hospital. Moreover, it is the responsibility of hospital psychiatry to foster new knowledge in the prevention and treatment of mental illness, and to search for its causes. For many years the Commonwealth of Massachusetts has provided a modest research budget, but this is too limited to satisfy the needs. Nevertheless research is going on at an accelerated rate, largely by support from Federal and foundation grants, although much of the cost in overhead and in staff activities is borne by the Commonwealth. Despite the generosity of the support, however, the project grants are time-limited from one to three or five years, so that a continuing permanent staff is not available. It is gratifying, therefore, to record that this year's state budget includes five new positions for research personnel, which will give much needed continuity. As a result it is certain that greater progress will be made, and that more funds from outside sources will become available.

PROFESSIONAL TRAINING

Professional education is likewise of great significance, and for many years Massachusetts hospitals have been active in giving instruction in psychiatry in the medical schools of the state. Graduate training is offered in the form of residency programs. The approval of a mental hospital as a training center is prized as recognition of the work being done and the instruction that can be offered. At present 8 out of our 12 state hospitals are approved for residency training, as is one of our state schools. Other training programs include programs for nurses, psychiatric social workers, occupational therapists, psychologists, chaplains, and others. In-service training has been strengthened for many professional and sub-professional groups. The largest program has been in the training of attendant nurses so that they may qualify through examination for the newly created position of Licensed Practical Nurse. About 2,000 individuals have passed this examination. The creation of this category in Massachusetts by legislative enactment and budgetary approval has been one of the most important advances in recent years, providing the possibility of immeasurable improvement in the nursing capacity of our employees.

The record shows that 23 new buildings have been constructed for the Department of Mental Health within the past four years. At first glance this seems like a large construction program. But it will be seen in new perspective when it is realized that there are 1190 separate buildings on the properties of our 18 institutions, and that many of these are dilapidated fire hazards and no longer functionally satisfactory. Moreover, of these 23 buildings, only 8 are directly for patient use; another 8 are new service buildings, or additions to old ones; 2 are for employee housing, and 3 for auditoriums, gymnasiums, and school facilities.

One entirely new hospital, Cushing Hospital at Framingham, represents a milestone in the care of elderly patients. This was an army hospital during the Second World War, and was later used by the VA. A few years ago it was made available to the Commonwealth, which has turned it into an institution for the elderly who are incapable of looking after themselves because of physical disability with mild mental symptoms, but are not necessarily in need of commitment for mental illness. These people are being cared for under the Department of Mental Health in a most satisfactory manner. They pay for their care, either through private sources, or through Social Security, Old Age Assistance, or disability allowance. Unfortunately this is the only hospital in the state whose patients are permitted Old Age Assistance and disability pay.

MENTAL HEALTH CENTERS

While it must be recognized that many of the existing obsolescent buildings must be demolished and replaced, it does not follow that large new buildings should be placed in the same locales. For the most part, small new buildings should be placed on different sites, thus defeating, at one blow, Parkinson's Law and the isolation of the mentally ill. Our general plan is to establish centers for mental health services in the larger cities, in close proximity to and in close association with general hospitals and general medical facilities in these areas. Approximately six such centers will be strategically placed in the larger population centers to afford pre- and post-hospital community care for all ages. Full-time hospitalization will be available where indicated. A center will consist of a sufficient number of beds to care for the needs of the area, with day- and night-hospital services, and clinics for those not needing hospitals or day-care, or for patients resident in the community after discharge. The clinic will also provide diagnostic and treatment facilities for emotionally disturbed children, for retarded children, for adolescents, and for adults in early, middle, and later life. Each center will be under the management of a nearby state hospital so that there may be an exchange of staff. It will have close association with the community general hospital for such services as operative, laboratory, X-ray facilities and so on. A unit with 40 beds for inpatients can serve a population of considerably more than 100,000. It will admit and treat some 240 patients a year, since experience shows that in most cases, an average stay of 30 to 45 days will suffice. With social service workers and rehabilitation and placement officers working in the local area, proper attention can be given to the needs of

the patients, as well as those of their families. This will aid immeasurably in community acceptance.

In Boston it is proposed that one unit with 120 beds and a similar unit with 60 beds shall be established, and the Legislature, at the Governor's request, has provided funds for a preliminary architectural study and design for these two sizes of unit.

EXPANDED SERVICES

The over-all state plan calls for an orderly addition of these facilities and services throughout the state. In addition, the mental hygiene clinics, to be increased from 18 to 43, will attempt to expand their services to take care of adults as well as children, and new cases from the community as well as patients discharged from the nearest state hospital.

With the completion of the plan, there will be two relatively large intensive treatment, training, and research centers in the heart of the metropolitan district (in addition to the larger Massachusetts Mental Health Center), 6 moderate-sized centers, and a considerable number of outpatient clinics, as well as the already existing state institutions. These facilities will embrace all the problems of the various ailments and disorders in the fields of mental illness and retardation. Thus services will be available at a short distance from the homes of most of the citizens of the Commonwealth.

Within less than three years, therefore, it has been possible for a large state to develop a practical program based upon techniques which were barely in the experimental stage in 1958. Moreover, Massachusetts is by no means the only state in which such a program has been developed. Iowa, with its community plans, the Western states, under the leadership of WICHE, the southern state of Georgia, with its sad plight of one 12,000-bed hospital for the entire population—these and many others are developing similar supporting services, community-based, but closely related to the mental hospital and to other medical services.

THE CHRONIC HOSPITAL POPULATION

The basic problem remains, however. What are we to do about the long-term mentally ill patient, whom, with all our knowledge, with all our good-will, we cannot yet restore to health? In 1958, I suggested that we should establish special facilities for these people, and that a new discipline be developed for their proper management. I mentioned the resource potential of social group workers, educators, public health personnel, and sociologists, and suggested that the emphasis should be centered upon rehabilitation activities.

"The prospects remain grim," I said, "unless new ways are found to meet the needs of these patients. . . . Unpalatable as it may appear, one must face the fact that we are doing little by way of definitive treatment of a large number of our chronic hospital population. . . . I suggest we take a new look at the problem."

Again today, I stress that the most urgent need is for an increase in the number of professional personnel to explore this problem; this should include more and better trained psychiatrists, highly competent social workers, and a new complement of rehabilitation and vocational training officials. In 1958, I offered as a working definition for this type of rehabilitation "the best utilization of the capacity of a disabled individual." I cannot improve on this today. I hope we can create a new, specialized group of workers for the rehabilitation and development of the maximum potential of these individuals whom we are not yet capable of leading to full recovery.

I believe that, with the community programs we have been discussing, it is possible today to make a beginning in effectively treating these chronic patients. As our hospital population continues to decrease, and as our new buildings are constructed progressively smaller, more intensive, special programs can be geared to the needs of long-term patients. As in all human endeavors, we have started with the problems which are easiest to solve—but at our peril, we neglect the more difficult one.

So it seems that my message to you as a Past-President does not differ greatly from what I said to you nearly three years ago. Today we can point, however, to some practical applications of the methods and techniques I discussed then. Small hospitals, highly trained staff, research, education, and community support—these are our armaments for the decade to come. •

Small World

A TRANSATLANTIC CONFERENCE of top medical and psychiatric leaders in the United States and Europe, for the purpose of attacking mental health problems, took place on August 12. It brought together, via a transoceanic telephone hook-up, two meetings of the World Federation for Mental Health. In Edinburgh, Scotland, a panel of four doctors, attending the 13th annual meeting of WFMH, electronically joined a panel of Americans located at the Carnegie Endowment for Peace in New York City to discuss the particular problems of the aged.

The American panel, under the chairmanship of Dr. Margaret Mead, the well-known anthropologist, was composed of two psychiatrists (Dr. Jack Weinberg of Michael Reese Hospital in Chicago, and Dr. Maurice Linden, director of the Philadelphia division of mental health) and one social worker, Miss Ollie Randall, consultant to the 1950 White House Conference on Aging.

Dr. Doris M. Odlum, former president of the European League for Mental Health and a consulting physician for psychological medicine at a number of British hospitals, served as chairman of the Edinburgh meeting. Participants on this panel were Dr. David Ross, physician-superintendent of the Stratheden Hospital, Cupar, Scotland; Dr. Andre Repond, a Swiss pioneer in psychiatry, mental health, and geriatrics; and Dr. George Macdonald Bell, physician-superintendent of Dingleton Hospital at Melrose, Scotland, and a pioneer of the modern open-door hospital.

The transoceanic hook-up was arranged by Smith, Kline and French Laboratories of Philadelphia, Pa.

Psychiatric Profile of the West:

DETAIL—UTAH

"MENTAL HEALTH personnel shortages are already more serious in the West than in the country as a whole," said Warren T. Vaughan, Jr., M.D., Director of the Mental Health Training and Research Project of the Western Interstate Commission for Higher Education, at the Western Divisional Meeting of the A.P.A. in Seattle last year. "However, the West's demands for mental health services will increase," he continued. "Not only is the West's population increasing more rapidly than in the rest of the country, but this increase will be disproportionately high for the youngest and oldest age groups. This will result in increased demands for psychiatric services. . . ."

In ten years' time, Dr. Vaughan declared, the 13 Western states (Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming) will need 700 community mental health units to serve an expected population of 35 million. The West should be producing a minimum of 1100 medical graduates a year, 500 more than the current graduation rate. To do so will call for at least three new medical schools, and the expansion of existing schools by 25 per cent.

Five years ago the western governors, recognizing the severity of the personnel shortages in mental health, instructed WICHE to conduct a survey of mental health training and research in the West. The survey, conducted under the direction of C. H. Hardin Branch, M.D., head of the Department of Psychiatry at the University of Utah College of Medicine, urged a regional or interstate approach to the problems of training and research. As a result, WICHE began a mental health program in 1957 with financial assistance from the U. S. Public Health Service. The Western Mental Health Training and Research Council was formed, and is now a thriving planning and development group of representatives from each western state and each mental health profession, with several distinguished lay and governmental leaders.

The council serves as an advisory body to the WICHE mental health project staff, which, through its various committees, is designing and implementing specific programs of training and research. Plans include a career recruitment program, a psychiatric postgraduate program for physicians, a regional research advisory service, and regional training programs for career employees in public mental health institutions.

Against this general background of Western problems and attempted solutions, it is interesting to examine in more detail the state of Utah, where the 12th Mental Hospital Institute is to meet this month.

UTAH'S PROBLEMS AND PROGRAMS

One state hospital at Provo, with a rated capacity of 937, attempts to serve the state's population of 821,000. This hospital is some 45 miles from Salt Lake City. The patient load has dropped from 1400 in 1954 to the present 1100, and with more expansion from supporting professional agencies, and intensive work with families and communities, it is hoped to reduce the census even further. Some remodeling is underway, and plans are afoot for a new admission, diagnostic, and treatment building of about 200 beds. It is expected that the next Legislature will appropriate about two and a half million dollars for this purpose.

The 1957 Legislature authorized the construction of a ten million dollar medical center for the University of Utah. When this is completed in 1961, the center will have a psychiatric section and an outpatient clinic. Teaching, treatment, and research will be closely coordinated.

Most of the larger general hospitals in the heavy population centers of the state already have psychiatric units. At the 550-bed Latter-Day Saints Hospital in Salt Lake City, a modern psychiatric unit for 35 patients was completed last spring. Salt Lake County General Hospital, affiliated with the University of Utah College of Medicine, has a unit of 27 beds (22 in closed and 5 in open wards). Although the main program is short-term treatment, selected patients may be treated for as long as a year. All cases characteristic of a psychiatric receiving service in a large city are admitted. Two senior staff members of the University Department of Psychiatry serve as co-directors. Two or three residents work in the unit, and interns rotate through the service. Experience in clinical psychiatry is offered to four medical students for one month each year.

A third example of a psychiatric unit is in the Veterans Administration Hospital, located adjacent to the campus of the university. The psychiatric service at this hospital has 400 beds. The hospital is affiliated with the University of Utah College of Medicine. Residencies are offered in a wide variety of medical specialties, including psychiatry, as is training in clinical psychology and social work for graduate students. The hospital has research programs in all specialties.

Utah, according to Dr. A. H. Fechner, manager of the VA Hospital, is "woefully lacking in community mental health services." A mental hygiene clinic and a child guidance clinic in Salt Lake City, supported by U. S. Public Health Service grants, have demonstrated the value and need for such community clinics. At the last legislative session, a bill was introduced to permit the establishment of all-purpose mental health clinics in various localities, with the state providing matching funds to communities desiring to set up such clinics. The clinic program was to be supervised by a psychiatrist in the Bureau of Mental Health. Unfortunately the bill failed to pass, but it is expected that a similar one will be introduced shortly and will receive legislative sanction. Several communities in the state have been attempting to supply services through the use of mobile clinics, under the direction of the Mental Health Bureau, a division of the State Health Department. These traveling clinic teams already have long waiting lists.

MEDICAL EDUCATION PROGRAM

The state is justly proud of its completely integrated psychiatric education program, utilizing the facilities of the state hospital, the VA Hospital, and the Salt Lake County General Hospital. The program was developed by a committee of representatives from the three hospitals and the University of Utah College of Medicine, under the chairmanship of Dr. Branch. Every resident rotates for a specified period through each of the three hospitals, and selected staff members of the VA and state hospitals have faculty appointments at the university. They participate in the teaching of medical students, interns, and residents; university faculty members serve as consultants to the two hospitals. Everybody benefits from this tightly integrated teaching program: the standards of patient care are raised; affiliation with the university teaching program stimulates the full-time hospital staffs; and the additional clinical material broadens the base of teaching for the medical school.

Utah, with a total of 36 psychiatrists, has seen an increasing number of young men entering private practice in the state during the past four or five years. Most of them are graduates of the state's own training program.

THE COMMITMENT LAW

Utah has one of the most liberal commitment laws in the country, and was among the first states to make legislative changes consistent with the Draft Commitment Law written by the Federal Security Agency for the U. S. Public Health Service. A law which incorporated this model act was passed in 1951. There are in

Photos Courtesy Utah Tourist and Publicity Council

Utah four methods whereby a patient may be committed to the state hospital:

1. On a voluntary basis: This means that he is free to leave the institution upon written request, subject to 48 hours notice.

2. On a voluntary-involuntary basis: If the patient himself is unable to carry out the voluntary admission procedure because of his illness, two doctors designated by the Welfare Commission examine him and certify his need for hospitalization. As in the case of voluntary hos-

Theme of the Institute

"We ought to have a sociological study of the breakdown crises in the administration of mental hospital functions, and another study of unusually successful administrative functioning," said Dr. Kenneth Appel, then President of the A.P.A., at the Fifth Mental Hospital Institute in 1953. This statement, which led indirectly to the formation of the Joint Committee on Mental Illness and Mental Health, might well be the keynote for the Twelfth Mental Hospital Institute, to be held October 17 through 20 at Salt Lake City, Utah.

The main topic "Needs of the Mentally Ill: Types of Effective Action Between the Community and Its Hospital Facilities" is sociologically oriented to the various "communities" with which hospitals are related: controlling and finance bodies, professional groups, community service organizations, scientific and educational groups, the personal community from which the patient comes, his social group in the hospital, and the general public. Participants are to discuss their experiences with these groups, and spell out successes and failures in working with them.

The only program change is the replacement of Dr. Wayne Yeager, of Florida, who is unable to attend, by Dr. David J. Vail, Medical Director of the Department of Welfare, Minnesota. Those already assigned to Dr. Yeager's group are being notified that they are to work with Dr. Vail instead.

pitalization, the patient may request release at any time and must be granted this unless the superintendent obtains legal authority to detain him.

3. On emergency procedure: Used only in extreme situations, this provides for a health or police officer to place the patient in the hospital immediately, with or without the endorsement of the judge.

4. Involuntary or commitment procedure: This may be initiated by a friend or relative, who goes to the county clerk's office to give information substantiating the need for hospitalization. After reviewing the application—and any supporting material—the judge issues an order for two designated physicians to examine the patient, who may be detained meanwhile if the judge considers he is likely to harm himself or others while awaiting the examination. If, following the psychiatric examination, there seems no need for hospitalization the judge can dismiss the case without a hearing. Otherwise a hearing is held in a physical setting not considered harmful to the patient. In practice such hearings are usually held at the Salt Lake County General Hospital. Only those immediately involved—the family, close friends, medical and social work personnel, and legal counsel—are permitted to be present.

"Since the inception of the 1951 commitment law," writes Barbara K. Varley, M.S.W.,[1] "lawyers involved in commitments have become adept in helping the patient accept that which is best for his mental health. If desirable, the patient attends the hearing, but he is not compelled to do so. However, most patients are urged to appear so they may feel they have participated in the decision.

"Because of the nature of the Utah commitment law, and because the intent of the law is to facilitate treatment, the judge is patient-focused and often helps the patient to recognize hospitalization as a necessary medical rather than punitive procedure. . . . Most patients accept the recommendation of the court, and their response is directly related to the sincere efforts on the part of the judge to be an active participant on the psychiatric team assiting in the treatment program. Without question, the judge's judicial position has significance to the patient, and when the judge uses his position of authority in a constructive manner, he makes a unique contribution to the treatment of the mentally ill. . . .

"At all times the final decision on commitment rests with the judge, who generally acts on the medical recommendation. . . .

"The single question before the court is whether the patient is mentally ill and is therefore in need of hospitalization. . . . Should it be assumed that the individual is incompetent and in need of a legal guardian a separate hearing is held. . . ."

The Utah law has been criticized by some as being too broad; however, those who have worked with it declare it to be generally beneficial to patients and their families. •

[1] *Varley, Barbara K.: The Legal Profession as a Member of the Psychiatric Team, Ment. Hyg., 44:3:368-374 (July) 1960.*

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The Brief Case

II. Suing a Public Mental Institution

THE PSYCHIATRIST ON THE WITNESS STAND may wonder what devils of legal, state, and national perversity have summoned him to such an ill-rewarding situation. A fellow physician, for instance an orthopedist, may feel confident that he will do a good job of contributing to the knowledge of those present, and may step away with a sense of professional prestige maintained. But the present-day psychiatrist may be sure of nothing, except that he is being heard. He may hope to lay the groundwork for new laws which will benefit the community as a whole, but on the other hand, he may, with justice, fear that his contributions will be misunderstood and will lead instead to a new form of legal lag.

The psychiatrist, whose profession is in process of rapid development and change, must remember that the law, on the contrary, holds tenaciously to principles which have become established through many a precedent. Some of these principles are very ancient. One of them may make it impossible for today's mentally ill citizen to bring suit for personal injury against the state hospital in which he is a patient because it was decided in medieval times that no one could sue the sovereign state. (This was based upon the concept that the king could do no wrong.)

Exceptions have been made, of course, and today various types of suits will lie, with its consent, against the sovereign state. But the legal armour which this ancient doctrine created has rarely been penetrated by mentally ill persons suing the state in tort. (As used here, "suit in tort" is limited to mean a suit involving alledged injury to a person resulting from the negligence of another.)

Statutory provisions in a number of states permit citizens to sue the state, but some particularly exclude patients in state hospitals by providing that a hospital functioning under the exclusive ownership of the state is not liable for the negligence or misconduct of its employees.

It is interesting to note that Idaho once set up a system whereby a patient in its state school and colony could recover for injuries, if the superintendent was found guilty of a "statutory omission." The state did not expose itself to suit, but allowed recovery against the superintendent and/or the insurance company which had written his "official bond." Furthermore if his statutory omissions were in excess of the coverage of the bond, the superintendent was personally liable for the extra cost. A case in point is that of *Sims v. United Pacific Insurance Co. 51 F. Supp 433 (1943).* In allowing recovery for the plaintiff, the court said that "under the Idaho statute requiring the medical superintendent of the State School and Colony to prescribe treatment of patients, the superintendent's refusal to diagnose an inmate's spinal injury constitutes a failure to perform a ministerial and not a discretionary duty." Idaho has since repealed this law and now once more conforms to the general rule.

In 1946 the Federal Government, by statute, exposed itself to suit in any of its Federal hospitals or other agencies by passing the *Fed. Tort Claims Act.* Under this act, the U.S. waives its immunity from liability in tort and makes the Federal Government liable under local law, where the tort occurs, for negligent or wrongful acts or omissions of Federal employees within the scope of their employment. The following cases are examples of suits brought under this act.

Lange v. U.S., 179 F. Supp. 777 (1960): A patient in the neuropsychiatric service of a Veterans Administration Hospital was declared to have suicidal tendencies, and proper precautions were ordered. While unguarded, he committed suicide by jumping from a sixth floor window. In awarding damages to his mother, the court said ". . . In the exercise of reasonable care, with this notice, the jump could have been anticipated, and the fact that he was unattended and alone for the shortest period of time is enough to establish lack of due care on the part of the government employees and liability for the death. . . ."

Fahey v. U.S. of America, 153 F. Supp. 878 (1957): The parents of the victim of a murder, committed in 1952 by a war veteran, brought suit against the Federal Government for damages, contending that the Government was negligent in allowing the veteran to be at large. From 1942 to 1945, the veteran had been treated in an Army hospital. His diagnosis, according to the hospital, was dementia praecox. In 1945 he was discharged with a 50% disability rating. In August 1948, a Rehabilitation Board psychiatrist reported to the Adjudication Officer that the veteran had a 50% psychotic disability. Later that year he was examined by VA psychiatrists, who noted his history, found him to be "schizophrenic in partial remission," and subsequently declared him not competent to discharge his own affairs. In 1951 he was adjudged incompetent by a Probate Court and a guardian was appointed.

In denying damages to relatives of the murder victim the court held that there was no negligence on the part of the Government in failing to cause the veteran to be committed to a mental hospital. The Federal Government has no such constitutional or inherent power. The fact that the United States gives certain benefits to veterans does not imply a duty to protect the public from their actions. The VA regulations relating to emergency hospital treatment, hospitalization for observation, and examination of lunacy or guardianship are permissive, not mandatory. The court further stated that "the acts of the psychiatrists involved come within the scope of the term

'discretionary functions.' They were retained to make professional diagnoses and if any error was committed it was an error in the exercise of their authorized discretion. . . ." The court interpreted such conduct as being excepted by the *Fed. Tort Claims Act* which specifically bars claims based "upon the exercise or performance or the failure to exercise or perform a discretionary function or duty on the part of a Federal agency or an employee of the Government whether or not the discretion involved is abused."

The Federal Court in this case found it necessary to point out the intent and meaning of the statute. Where the legislative language, in the opinion of the courts, is not clear or sufficient, meanings may be written into statutes that were never intended by the legislatures. A failure to convey meaning can endanger the actual intent of the legislative enactment. It is not too surprising therefore, that courts and legislatures, in enacting and promulgating legal provisions, find difficulty in expressing the rules of law in terms of a relatively new science such as psychiatry. In a sense the psychiatrist on the witness stand may take comfort from the fact that those who write and pronounce laws also find difficulty in conveying precise meaning. But in working with the people whose business it is to formulate rules for the conduct of others, he must certainly recognize their striving to obtain a better understanding of the persons for whom the laws are made.

(Problems involving suits by patients in private psychiatric hospitals will be discussed in a subsequent issue.)

PHYLLIS WOODWARD, LL.B.

Have You Read?

PSYCHIATRIC TREATMENT RESOURCES – A Guide for the Family Physician–by Charles E. Goshen, M.D., Washington Clinic, Washington, D.C. This 20-page article is reprinted from the April and May 1960 issues of *Medical Times*. It describes in detail all the types of facilities available for the care and treatment of the mentally sick, adult and child: public and private mental hospitals; psychiatric services of general hospitals; day- and night-hospitals; clinics; community facilities, such as sheltered workshops, half-way houses, foster home care, patient-sponsored clubs, family guidance programs. One section is devoted to the private practice of psychiatry.

COMMUNICATING WITH SCHIZOPHRENIC PATIENTS, by Alice M. Robinson, R.N., M.S., in the August issue of *The American Journal of Nursing*. "Communication is the most prodigious problem in schizophrenia. Yet it is this barrier we must penetrate if our efforts to nurse these patients are to be successful. . . . Despite the 'power of the the schizophrenic,' despite the personal inadequacies of the nurse, there is much to be said for this tool of 'love' in overcoming the problem of communication in the relationship of the nurse and the schizophrenic patient." This article is excerpted from a paper presented at the Nebraska Psychiatric Institute in Omaha on April 10, 1959.

THE ATTITUDE OF INDUSTRIAL EMPLOYERS TOWARD HIRING OF FORMER STATE MENTAL HOSPITAL PATIENTS–by Vytautas J. Bieliauskas & Harvey E. Wolfe. This study, which appeared in the July issue of the *Journal of Clinical Psychology*, was conducted in the Cincinnati area and covered all manufacturing firms, 251 in all, employing 100 persons or more. The findings were as follows: only 5 per cent of the employers showed enthusiasm about hiring former patients; 37 per cent were interested; 32 per cent, mildly interested; 16 per cent showed some hesitation; and 8 per cent were completely opposed to hiring such patients. (2 per cent replying were about to leave the area.)

LOOK AT YOURSELF, by Catherine Ring. This is "a frank account of a student's reactions while caring for an attractive young man who was emotionally ill." It appears in the August issue of *The American Journal of Nursing*. Miss Ring is a senior at the University of Vermont School of Nursing in Burlington. She wrote this article in her junior year during her psychiatric nursing affiliation at the Boston University School of Nursing and the Massachusetts Mental Health Center.

YOU, YOUR CHILD & EPILEPSY–A new leaflet for parents of epileptic children was published in June by the Federal Association for Epilepsy. It was written by Dr. John Nardini, chief of neuropsychiatry for the U. S. Navy, and Miss Genevieve O'Leary, chief psychiatric social worker at the Children's Center of the Catholic University of America. While aimed primarily at parents of epileptic children, the pamphlet will also be useful to social workers, public health nurses, physicians, teachers, psychologists, and other professional people who come in contact with family problems. Single copies are available, free of charge, from the Federal Association for Epilepsy, 1729 F Street, N.W., Washington 6, D. C.

HOW TO DEAL WITH MENTAL PROBLEMS–by Harry Milt, director of public relations of N.A.M.H. The feature item in the Better Mental Health Campaign, this pamphlet tells how to deal with the mental problems of the disturbed, maladjusted, troubled people one meets in everyday life–on the job, in school and at home.

The first issue (June) of MEMO-RAN-DUMBS by Ralston S. Bauer, the coordinator of volunteer services for the State of Indiana, was sent out to all directors of volunteer services in mental hospitals and state school settings in Canada and the U.S.A. This small publication, which Mr. Bauer hopes will be the forerunner of an official newsletter, gives news from various parts of the country about what volunteer directors are doing, what their plans are, and so on.

EVALUATION OF A RELATIVES' CONFERENCE

By JACOB BROUWER, and ALVIN R. HOWARD, Ph.D.,
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VA Hospital, Sheridan, Wyoming

IN ANY ATTEMPT to set up a relatives' conference, the hospital's primary objectives and the objectives of the relatives are often quite different. Also, preconceived opinions are apt to change after the conference is over. Therefore, it must be a give-and-take proposition, satisfactory as well as illuminating to both groups.

This was graphically demonstrated to the staff of the VA Hospital in Sheridan, Wyoming, when they conducted a before-and-after survey of a relatives' conference. These two-day meetings at the hospital are planned to make subsequent visits more meaningful to the relatives themselves, to the patients, and to the hospital staff.

Prior to this particular conference, questionnaires were sent to all invited families in an attempt to find out just what they hoped to glean from the meeting. The same questions, with only a change of tense, were given to attending relatives at the end of the conference. The staff compiled, therefore, two schedules of data, one a pre-test, and one a post-test.

BROAD COVERAGE

Invitations had gone to all relatives living in Wyoming, Montana, Northern Colorado, Western Nebraska, Idaho, Utah, and South Dakota. The staff was surprised to learn that neither the vaunted Wyoming distances nor the publicized weather was stated as a primary reason for failure to make the trip. Physical health and vocational commitments actually led, with such reasons as financial deprivations, other arrangements scheduled, and dependency on others for transportation, playing fairly heavy parts among remaining reasons. Old age, although not specifically mentioned, was an apparent factor among parents of long-hospitalized patients.

The first question on both the pre-test and the post-test dealt with the relatives' expectations of the conference. Before the meeting their answers were in very general terms, probably because they did not know exactly what to expect. The post-test results, however, were much more specific and individualized. The primary expectation of those who planned to attend was one of increased education. They desired to learn more about the illness of their patient-relatives, mental health in general, and the hospital's treatment program in particular. That they realized their expectations was obvious from the fact that the majority of responses on the post-test referred to an increase in knowledge, especially concerning aspects of the hospital program.

In question two, when asked with whom they would like to speak privately at the hospital, most relatives indicated on the pre-test that they wished to confer with their patient-relatives' ward physicians. Attending relatives reported, however, that they had conferred primarily with a social worker, and secondarily with other staff members who happened to be on the program. This was, of course, due mainly to staff availability.

Prior to the conference, this matter of private consultation with a staff member was viewed as the "most important" element by those who expected to come. Those who did not plan to attend saw both this and visits with patient-relatives as most important. The post-test indicated a significant change of opinion, as formal lectures and visits with patients received, roughly, twice as much emphasis on these returns. Only three of the entire post-test group felt individual consultation to be most important. Two reasons could be assumed for this change of opinion. First, relatives had found it impossible to consult privately with (primarily) the ward physician. Second, the lectures and ensuing discussions fulfilled their primary expectations of learning something of value from the conference.

The last question on both tests was designed to sum up the individual reaction to the total conference. Again, as in the preceding questions, the pre-tests emphasized the importance of visiting patient-relatives and consulting staff members. Once more the post-test answers seemed to stress a better understanding of the hospital treatment program and, in some instances, a realization of the family member as part of the team. Several saw everything they experienced as educative, others learned about staff cooperation. The need for visiting relatives more often was a realization of many.

Although informal mixing with other relatives was not recognized as an important element by the families, staff observation showed that this was probably an intangible value. People from all stations of life came together with a common purpose, shared a common experience, and mixed informally with mutual satisfaction. From observation and written and verbal endorsement, the hospital was able to conclude that all returned home glad to have been at the conference.

MUTUAL BENEFIT

Further, the beneficial aspects of the conference were not confined to the relatives. The sick veteran enjoyed the attention of his relatives, and took pride in his hospital contacts and achievements. Staff members gave extra time to participate in the program. They showed their interest in each patient and met his family members. Most importantly, they were able to take a better look at the total patient. •

Past Perspectives and Future Vistas

By MIKE GORMAN
Executive Director
National Committee Against Mental Illness
Washington, D. C.

WITH THE ESTABLISHMENT of the first public hospital in the Commonwealth of Virginia in 1773, there developed the philosophy that the insane were untreatable and incurable, and therefore should be mercifully relegated to custodial institutions far from the centers of population.

Over a period of a century and a half, there were remarkably few changes in this custodial attitude. In most states, the mental hospitals were lumped together with penal and welfare institutions under over-all Boards of Institutions or Boards of Welfare.

As a newspaper reporter in Oklahoma after World War II, I discovered a situation which was all too typical of conditions throughout the country. The mental hospitals were thrown together with all other "eleemosynary" institutions, a detestable classification straight out of Charles Dickens. At the annual legislative hearing on their budgets, the superintendents of the various institutions would vie with one another in describing how little money they had spent and how much they were turning back to the state. And this in the days when most of these institutions were spending less than a dollar a day to provide food, clothing, shelter, and medical care for each patient!

Apart from humanitarian considerations, the operation of most of these institutions struck many of us as extraordinarily uneconomic. Because salaries were frightfully low, the turnover of personnel was exceedingly high. Although the daily maintenance cost per patient was minimal, the lengthy hospital stay of the average patient—eight years—meant that the average cost per patient involved a large tax outlay.

THE COST OF CUSTODY

Because the emphasis was upon custody rather than intensive treatment, the need for additional institutions created a serious financial problem for the states. From 1944 through 1955, for example, the resident population of state mental hospitals was increasing at the rate of 12,000 patients a year. This massive addition of more than 100,000 patients in a decade necessitated the allocation of hundreds of millions of dollars of state revenue for new buildings. In many states, because of the tight revenue picture, this additional construction had to be financed through the expensive fiscal mechanism of bond issues.

Under the impact of seemingly endless construction programs and mounting hospital maintenance costs, a number of state governors began searching for a way out of the bleak custodial morass which had really existed since 1773. The Council of State Governments was therefore ordered to prepare several studies on the financing of state mental hospitals and on suggested alternatives to the existing policy of piling brick upon brick and patient upon patient.

The Council's 1953 report, "Training and Research in State Mental Health Programs," outlined a new and daring philosophy in these challenging words:

> "Care and treatment for mental patients are continuing, major functions of the state governments. . . . But care and treatment alone, along present lines, cannot cope with the present and emerging situations. Hope for the future lies primarily in widening and deepening the knowledge of mental disorder—in the discovery and application of better means of treatment and prevention. These can be attained only through more research, and through training of mental health personnel. Research and training thus are the essential bases for reducing admissions to mental hospitals and, ultimately, for reducing hospital populations."

To implement these recommendations, the governors called a special conference on mental health in 1954. This conference advocated both professional direction of state mental hospital systems, and line item appropriations for research and training.

These recommendations bore considerable fruit. A number of states created separate departments of mental health, and in many others, highly qualified psychiatrists were brought in to replace the patronage appointees of the old era. A few states even established directorships of research and training, and the present $32 million which the states spend on research and training is a dramatic contrast to the few millions of a decade ago.

Tying in with these progressive developments was a growing ground swell of revolt against the big mental hospital. In 1953, an expert committee on mental health

Ed. Note: This article is based on an address which Mr. Gorman gave to the 87th Annual Forum—National Conference on Social Welfare, Atlantic City, New Jersey.

of the World Health Organization reported that "the widespread belief in the economy of very large hospitals is probably unfounded. . . . Above 400 beds, the cost per bed begins to increase slowly and reaches rather high figures above 800 beds. The reason is probably uncontrollable wastage, lack of responsibility on the part of too large a staff, unnecessary buying, and an industrial type of mechanization which is inevitable in very large hospitals; one must add to these the impossibility of sustained personal contact between the director and hundreds of hospital workers."

THE EMPHASIS SHIFTS

With the growing realization that it was impossible to attract to these isolated institutions top-flight professionals, the emphasis began to switch slowly but surely to the development of new mental health facilities in the heart of the community.

In 1954, New York became the first state to enact a community mental health services law which provided for joint state and local financing of additional clinical services, psychiatric units in general hospitals, psychiatric services in the schools and courts, and a whole host of additional devices designed to return the treatment of mental illness to the community. Since the passage of the New York law, a number of states have enacted similar legislation.

The National Institute of Mental Health recently estimated that Federal, state, and local support of these new community mental health services reached the level of $64 million in 1958. This compares with the few million dollars which went for support of these activities only a decade ago.

The best example of this remarkable transition from custodial maintenance of mental patients to intensive treatment of incipient mental illness is provided by the remarkable growth of the psychiatric unit in the general hospital.

In 1902, the first psychiatric unit in a general hospital—established by Dr. J. M. Mosher at the Albany Hospital in New York State—contained 25 beds. In 1958, it is estimated that there were over 24,000 psychiatric beds in general hospitals in almost every state in the country. At the present time, over 950 general hospitals admit psychiatric patients as against approximately 50 hospitals admitting them just two decades ago. (Statistics from an unpublished study "Survey of Psychiatric Patients Cared for in General Hospitals, 1954-1958"; First Draft. Joint Information Service, A.P.A.–N.A.M.H.)

In 1956, for the first time in the history of the care of the mentally ill in this nation, more mental patients were admitted to general hospitals than to state mental hospitals.

In Texas the movement actually goes back to the opening, in 1934, of a small psychiatric unit at the medical branch of the University of Texas at Galveston. Dr. Titus Harris, the chairman of the Department of Psychiatry, pointed out recently that the success of the pioneer unit at the university convinced most of the psychiatrists training there of the need for general hospital psychiatric units in the successful practice of private psychiatry. As a result, many of the 27 psychiatric units in general hospitals in Texas are located in small towns.

The second largest mental hospital in the world is located at Milledgeville, Georgia. It has 12,000 patients, and because of its geographic isolation it has been unable to attract top-flight medical personnel.

In 1957, the Georgia Legislature therefore approved a bill authorizing the state health department to establish psychiatric units throughout the state. Units have been opened in Atlanta, Macon, and Columbus. The program has been remarkably successful. Despite average per diem rates of $20 to $30 in the general hospitals as against the $3 per day at Milledgeville, the general consensus is that it is still cheaper to handle the mental patient in the municipal psychiatric unit. For example, of 422 patients discharged during the first 15 months of the program, only 9 per cent were referred to the state mental hospital for prolonged treatment.

TREATMENT IS FLEXIBLE

The advent of the psychiatric unit in the general hospital, combined with health insurance coverage, is but one example of the modern trend away from lengthy 24-hour commitment of the mental patient. In recent years we have followed the example of many European countries and Canada in developing flexible treatment facilities designed to shorten the amount of time spent by a patient in an institution. Day- and night-hospitals, half-way houses, and aftercare clinics are all attempts at retaining family and community ties as key factors in the therapeutic process. In the last several years we have even seen in the New York and Boston areas the development of emergency psychiatric services where a disturbed patient can receive psychiatric first aid at any time of the day or night without the enormous inhibition of legal commitment.

These exciting sociomedical developments have been greatly enhanced with the advent of inexpensive medications which can be given to psychiatric patients in the office of the family physician or in an outpatient clinic setting. The widespread use of the tranquilizing drugs by the family physician has dramatized the return of psychiatry to the main stream of American medicine. The general practitioner is becoming increasingly oriented to the emotional dynamics underlying illness. The American Academy of General Practice and the American Psychiatric Association have joined forces in planning psychiatric courses for the family physician, and the National Institute of Mental Health last year supported the residency or postgraduate training of 1,500 general practitioners.

These revolutionary developments have shaken up the stagnation of the average mental hospital. Intensive application of the drugs, plus an appreciable increase in medical personnel, have resulted in an unprecedented reduction of 16,000 patients in our state hospitals over the past four years.

Not that psychiatric care is now available to all Americans regardless of income. To the contrary, Drs. Frederick C. Redlich and August B. Hollingshead have documented in their "Social Class and Mental Illness"

the extraordinary degree to which lower and middle-income families are deprived of private and community psychiatric care. The Yale study pointed out that for most families not in the high income brackets, the public mental hospital is the first and frequently the only point of contact.

Insurance coverage of mental patients in general and private psychiatric hospitals would provide a partial answer to most of this problem. Unfortunately, coverage of mental illness by Blue Cross is sporadic and inexplicable. For example, although Cleveland Blue Cross has covered mental illness for more than 20 years for a maximum of 120 days per year, most of the comparable Blue Cross plans provide much more limited coverage or no coverage at all.

The standard arguments against coverage of psychiatric illness do not hold water. For example, the argument that psychiatric illness is lengthy and unpredictable in duration is refuted by figures recently released by the Health Information Foundation which show that the average length of stay of a psychiatric patient in a general hospital is approximately 16 days. Five other major diseases have a longer average length of hospital stay.

REALISTIC REALLOCATION OF TAX DOLLARS

While some of these new psychiatric services are relatively expensive, they have not served to raise appreciably the total bill for the care of the mentally ill. It is more accurate to describe the financial aspect of this development as a *reallocation of the tax dollar from the support of long-term custody to the financing of short-term intensive treatment.*

A recent study by the Council of State Governments, "Tax and Fiscal Policy and State Mental Health Programs," indicates that appropriations for mental health comprise approximately the same proportion of the state tax dollar as they did ten years ago.

In 1958, the cost of maintaining state hospitals took about three cents out of every state tax dollar. In that year, according to the American Psychiatric Association, the annual per capita expenditure for mental hospitals was only $4.42—figured on the hypothetical basis of each American's contributing an equal sum for support of these services.

The really sharp increase took place in outlays for community mental health services, which tripled in the short period from 1956 to 1958. However, this meant that the average citizen was contributing twenty-six cents a year to these services in 1958 as against only nine cents in 1956.

In any attempt to define the proper levels of national expenditure against mental illness, we must relate our fiscal goals to the size of the problem.

We are fortunate in having some fairly precise data in this area. A 1958 study by the economist Rashi Fein estimates the direct cost of mental illness to our economy at more than $1.7 billion a year. This is a minimum estimate, since Dr. Fein points out that it does not include hospital construction, nor the cost of a considerable amount of private care for emotional disturbances.

The indirect cost of mental illness is more difficult to estimate. Dr. Fein comes to a minimum figure of $800 million as the loss in wages for patients resident in our public mental hospitals.

The important point here is not the exactitude of the estimates of the indirect cost of mental illness, but a real appreciation of the fact that emotional maladjustment is a heavy burden upon our society, whether or not we provide adequate monies to control it. In other words, we bear the below-the-iceberg costs of mental illness even if we insist upon continuing to focus upon the visible part of the iceberg.

HOW MUCH DO WE VALUE MENTAL HEALTH?

This really gets us back to the basic question of values. I don't see how we can plan our mental health expenditures in the next decade without some consideration of the value we place upon the emotional health of the individual citizen.

Fifteen years ago mental health officials pleading for more expenditures were generally treated as mendicants, and unsuccessful mendicants at that. There has been a considerable improvement since then, but I say to you in all earnestness that expenditures for mental health still have a very low priority in the thinking of most of the leaders of our society.

Our first order of business, therefore, is the creation of a deepened public understanding of the grave importance of financing those resources which will aid us in adjusting both to one another and to the stressful demands of this extraordinarily complex society.

Secondly, within the narrower frame of expenditures for mental health, we must continue to question the kinds of mental health services we choose to support. We have had much thinking along these lines over the past decade. The revolt against the big mental hospital and the increased emphasis upon intensive treatment facilities in the heart of the community are examples of the kind of basic thinking which must continue to precede future developments.

Because of the nature of our affluent society, many of us who have testified before federal and state legislative bodies for increased financing of intensive treatment services have been forced on many an occasion to restrict our case to the economic savings which accrue from support of such services.

The overriding consideration is the treatment and return to society of thousands upon thousands of sick individuals. This is the true measure of our worth as a society. In the same manner in which we talk of the right of a child to a good public education, we must talk of the right of every individual to psychiatric aid designed to make him a happier and more effective individual.

The basic goal, then, is the emotionally mature person in a society which places a high premium upon individual and personal aspirations and values. While I am certain that the achievement of such goals will eventually reduce both the direct and indirect costs of mental illness to society appreciably, I think these are but desirable side effects of an increased emphasis upon the importance of individual mental health and well-being in a democratic society. •

Community Contacts Improve Prognosis

MOST MENTALLY ILL PATIENTS have intense unsatisfied dependency needs. If there is nobody in the community to whom a patient can go upon his release, recovery may seem to him to be unrealistic, discharge a threat, and the future without hope. In order to determine the prognostic value of outside contacts, the Metropolitan State Hospital, Norwalk, Cal., recently carried out a pilot study. The hypothesis was that a satisfactory contact with relatives might be a favorable factor, while the absence of such a contact might be detrimental.

We first studied a group of schizophrenic men on one ward, who had been receiving group therapy for seven months. We divided these patients into two groups. The eight patients of Group I had very poor contacts with the outside. Some had received neither mail nor visitors in two months; others could not communicate with their visitors, or strongly rejected them. The ten patients of Group II had few but pleasant contacts with visitors. They showed an ability to converse, and indicated their desire for more visitors. Six months after the end of our study, nine of the patients in Group II had left the hospital, whereas only one from Group I had been discharged.

We conducted a similar experiment with two groups of women patients. Of the six women in Group I, none had recovered sufficiently within the six-month period to be discharged, and two of them had eloped. Six of the eight patients in Group II were on leave; the two who remained at the hospital had indicated a definite rejection of their husbands as their outside contacts.

Although our observations were made on small groups, they were statistically significant. They suggested that the outside contacts of a mental patient can be an important prognostic factor and that further research is indicated.

The results of our study may be valuable in planning treatment programs. For example, four of the patients studied had little contact with relatives; they were offered visitors—women volunteers attached to our rehabilitation department. Under the supervision of the psychotherapist, each volunteer was able to establish a relationship with a patient which was satisfying and enhancing to that patient's morale.

WILLIAM E. BINGHAM, Ph.D.
Assistant Chief Clinical Psychologist

THE MESSAGE CENTER

By DR. WHATSISNAME

IT WAS SUPPOSED TO BE A BIG SECRET. On Tuesday, representatives of the Civil Service Commission would swarm in and audit every employee's job. But the word spread through the hospital before it reached the superintendent's office. And how it spread! Everyone was going to be downgraded or promoted. Everyone would be interviewed. One person from each department would be interviewed. Every fifth attendant was a Civil Service spy sent to monitor your work. The story was garbled, but the kernel of truth was there.

How did the secret reach the employees—and how, in a few hours, did it spread to 800 of them? The answer is obvious: the grapevine. Here is the swiftest communication system in the hospital. It is more like a primitive tom-tom network than a modern electronic communication device. It spreads like a forest fire. It is grotesquely inaccurate and utterly irresponsible. It cannot be destroyed by cutting off one head, because it has more heads than a centipede has legs. The grapevine is put in motion by a slippery, ghost-like gremlin whom no one has ever identified. Its message is carried on whispered wings.

Its effects cannot be countered by blunt denials. The denials themselves enter the nebulous network and are distorted by it. In a psychiatric hospital the grapevine has an added dimension. Often, patients also know what's going on and their fantasies become inextricably entangled with the equally unrealistic fantasies of the rumor-spreading employee.

Presumably, secrecy favors the development of the grapevine, and candor discourages it. It may be that a conscientiously developed system for getting the truth down to the lowest rank would be a way of neutralizing the grapevine. Somehow between the superintendent's office and the man with the mop, the word gets lost or perverted. Here is a challenge for our new communications experts. Or, will they say of grapevines as is said of so much else, "if you can't lick 'em, join 'em"? •

Saint Elizabeths Hospital Opens a New Unit for
Maximum Security with Minimum Seclusion

By MAURIS M. PLATKIN, M.D.*
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John Howard Pavilion, St. Elizabeths Hospital
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SEPTEMBER MARKED THE FIRST ANNIVERSARY of the opening of the John Howard Pavilion, new maximum security unit at Saint Elizabeths Hospital in Washington, D. C. After a year of operation, the facility is beginning to confirm the idea of its designers that "livability" can be combined with security.

The Pavilion replaces 80-year-old Howard Hall which was also named after the English philanthropist, John Howard, who devoted his life to prison reform. Too small for the number of patients and outdated for the type of treatment program now conducted, the old building will be demolished to make way for other construction.

THE LAYOUT OF THE PAVILION

As shown in the photographs on succeeding pages, the John Howard Pavilion is a seven-story structure, including basement and penthouse, with a bed capacity of 396. Its basic design is T-shaped with the stem of the T facing North. Attached to the East wing of the T is a smaller rectangular structure which houses an auditorium at one end and a full-sized gymnasium at the other.

A 3½-acre recreation area is located at the rear of the building between the West and North wings. A 24-foot sunken wall which gives patients a less restricted view of the "outside" surrounds the area. There is a smaller exercise yard between the North and East wings.

The hospital staff arrived at the concepts behind the construction after an extensive study of its program needs and of other similar types of maximum security institutions across the country, including the Dr. Norman M. Beatty Memorial Hospital in Westville, Indiana, and the Ionia State Hospital in Michigan, as well as Federal prisons in Terre Haute, Indiana, and Chillicothe, Ohio. Much of the credit for the design of the building goes to Dr. Addison M. Duval, formerly the assistant superintendent of St. Elizabeths, and now director of the Division of Mental Diseases, Department of Public Health and Welfare, Missouri.

The first floor of the Pavilion is the hub of administrative, clinical, and auxiliary activities. To the left of the entrance, through a remote-control, dual-door "sally port" are offices for the medical staff, the various treatment disciplines, and the clerical staff. In the North wing on this floor are equipment and storage rooms for food service, and storage space used by maintenance personnel. The main kitchen is located in the intersection of the three wings. Across the hall is an area for storing and dispensing hospital supplies and equipment. The East wing contains auxiliary patient facilities, such as barber shop and canteen, and furniture repair and broom and brush shops, both used in industrial therapy.

**The views expressed are solely those of the author.*

At this level also is located the auditorium, which seats 254 people and has full-stage lighting for movies and professional productions, as well as dressing-room facilities. There is a small serving kitchen adjacent to the auditorium, for serving refreshments during intermissions. Religious services are held in the auditorium or in the lobby foyer, depending on the size of the congregation. There is a confession-booth backstage.

WARD AREAS

The patient areas of the building are on the second, third, fourth, and fifth floors. Each floor contains three wards, one in each wing. Each ward on the second and third floors has a bed capacity of 37, including two 14-bed dormitories, a 2-bed room, and 7 single rooms. These two floors are for patients requiring less supervision than those on the fourth and fifth floors, where the wards contain 29 beds distributed among two 4-bed rooms, three 2-bed rooms, and fifteen single rooms. To facilitate closer supervision of the patients on these floors the staff-to-patient ratio is a little higher. The nursing stations are so located on all wards that personnel have a good view of all the active areas. By taking only a few steps the sleeping areas can also be observed.

The dining facilities for the wards are located on each floor in the intersection of the T. The serving line divides the dining room into two sections, one to accommodate two wards; the other, one. The main kitchen is located on the first floor under the "stack" of dining rooms; food service is speeded up by means of a service elevator opening directly to each dining room.

All wards have new and modern furnishings and spacious dayrooms with television, libraries, and ping-pong tables. Each ward has an outside terrace adjacent to the dayroom. These terraces are enclosed by a protective screen and overlook the recreation areas. Adjoining the entrances to the wards are visitors' rooms, used generally by the patients' special visitors, such as lawyers, clergymen, and "outside" doctors. The main visiting room is on the third floor.

In the center section of the Pavilion are three elevators, two for patients and one for the staff and visitors. On the second floor, across the hall from the elevators, is located the medical and surgical service, including a dental clinic. It is equipped to handle all the patients' medical needs, except major surgery. At the second floor intersection of the T is a staff conference room, a photolab, and two classrooms.

The intersection on the third floor houses facilities for the print shop for the patient publication, and a completely furnished, but not yet stocked, library. On the fourth floor are two O.T. shops and a group therapy room. There is another O.T. area on the fifth floor, and also a hydrotherapy room.

In the basement of the intersection are a machine shop, storage and mechanical space, and the elevator pit. At the end of the East wing on this level is the floor of the gymnasium. The penthouse contains the elevator-machine rooms and additional mechanical space.

The 80-year-old Howard Hall (below) has outgrown its usefulness and will be demolished to make room for new construction. It is replaced by the new Pavilion.

DESIGN AND COST

The Pavilion was designed by the Public Buildings Service of the General Services Administration according to the specifications of Dr. Duval and the hospital staff. The unit was two years in the planning stage, the contract was let in July 1956, work started in October 1956, and the building was occupied on September 12, 1959.

Funds for the construction were allocated by Congress as part of the general building program which has been conducted on a continuing-need basis for St. Elizabeths since 1946.

The total cost of the building was $7,660,000, which includes the cost of demolishing Howard Hall and the expense of installing all new equipment and furnishings, medical and general; $1,129,000 of this figure covered the cost of putting in a steam tunnel from the hospital's central heating plant to the Pavilion.

BASIC CONSTRUCTION

The gross area of the building is 196,000 square feet. Its frame is of reinforced concrete. The exterior walls are brick, with stone and concrete trim. The exterior windows are aluminum-type sash. Tool-steel detention grids are used intermediately, and ringed detention screens are used on the interior.

Inside the building, partitions are tile on cinder block, plastered or covered with glazed tile, depending on the area. All ceilings are acoustically treated. The

doors are metal, and floors are covered with terrazzo, ceramic tile, or asphalt tile. The lighting is indirect, incandescent or fluorescent. The Pavilion is heated by a circulated hot-air system which is also used to distribute fresh air in the summer.

The 24-foot wall around the large recreation area is recessed into a 14-foot excavation so that the top of the wall is only ten feet above normal ground level. Inside the yard are three protective sun shelters for patients, particularly for those taking medications which make them susceptible to sunburn.

THE TREATMENT PROGRAM

All male patients admitted to the hospital on a criminal commitment are sent to the Pavilion, and although the general treatment principles of the service are those of a modern mental hospital, the administrative management of most of the patients is influenced largely by their legal status. The patients fall into several categories:

1. *Patients charged with a criminal offense but who have not yet been tried.* These patients either have been found by the court to be incompetent for trial or have been sent to the hospital for determination as to their competency. In either case, the hospital must decide whether the patient was suffering from a mental disease or defect at the time of the alleged offense, and, if he was so suffering, whether the crime was a product of the abnormal mental condition. These decisions are made in response to specific court orders, which are framed in accordance with the well-known Durham decision handed down by the U.S. Court of Appeals of the District of Columbia in 1954, which relieves a person of criminal responsibility if he was suffering from a mental illness or defect at the time of the crime, and if the crime was a product of the illness or defect.

The majority of patients sent to the hospital for competency determination are sent, as a rule, for a period not to exceed sixty or ninety days. Obviously, no comprehensive program of treatment can be set up for so short a period, nor can a valid determination as to competency for trial be made when a patient is under heavy ataractic medication. Only where it is medically imperative, therefore, is a planned course of treatment, ataractic or otherwise, given in these cases.

2. *Patients who have been found by the court to be not guilty by reason of insanity.* Because most of these patients have been in the Pavilion prior to their trial, they are familiar to the hospital, and pose minimal problems in diagnosis. However, they are still under the jurisdiction of the court, which must review and approve their release from the hospital, on either a conditional or unconditional basis.

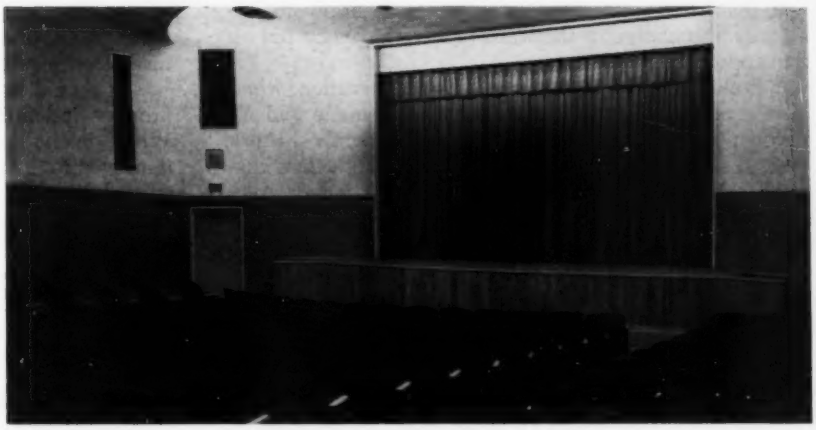
Sometimes the service receives patients in this category who are entirely new to the hospital and must be "worked up" from the beginning. In several cases the hospital has found that, contrary to the court's finding, a patient is without mental disorder. In such a case the hospital requests the court to grant the patient an unconditional release from the hospital.

3. *Patients who have been found by the court to be sexual psychopaths.* The District of Columbia Code defines rather specifically the conditions under which persons may be classified as sexual psychopaths. It states, "The term 'sexual psychopath' means a person not insane, who by a course of repeated misconduct in sexual matters has evidenced such lack of power to control his sexual impulses as to be dangerous to other persons because he is likely to attack or otherwise inflict injury, loss, pain or other evil on the object of his desire."

4. *Patients who become mentally ill while serving a sentence in certain Federal and District of Columbia prisons.* These patients are treated until they recover and then returned to the appropriate penal institution for completion of their sentence. If the illness extends beyond the expiration date of the sentence, steps are initiated for a civil commitment to retain the patient in the hospital for the duration of his illness. On discharge he is returned to the community, without further review by legal authorities.

5. *Patients in other parts of the hospital, who, though civilly committed, pose such problems in management—usually because of assaultiveness or persistent elopement tendencies—that they can best be managed in a security setting.* In practice few such patients are actually in the John Howard Pavilion at any one time.

The full-scale gymnasium shown at left occupies two floors of the East wing of new John Howard Pavilion.



The auditorium (right) on the first floor seats 254 people and is equipped for movies and stage productions.

In considering these groups of patients, it is apparent that under certain circumstances, the treatment program of the service is influenced by extrapsychiatric conditions. However, except for these special situations, treatment is effected through standard modalities of therapy and accepted methods of management. Some 40 per cent of the patients receive psychopharmacological medication in the form of accepted ataractic drugs. No "experimental" medications are used. All drugs used in the hospital, ataractics or otherwise, are first approved by a pharmacy board before their regular use is authorized.

The service has several therapy groups, including a special group for the sex psychopaths. It also sponsors an Alcoholics' Anonymous group under the leadership of "outside" AA personnel who conduct the meetings and maintain contact with the patients.

OCCUPATIONAL THERAPY

Three of the floors in the new building contain occupational therapy shops, including a variety of power machines for various mechanical uses. Patients who demonstrate the necessary degree of interest and responsibility for handling and working with the tools and machines available are approved for occupational therapy.

The Service publishes a monthly periodical, the *John Howard Journal*, written, edited, and printed by the patients. The Occupational Therapy Department provides modern printing equipment.

PATIENT GOVERNMENT

The service promotes—and it is one of the first maximum security services in a mental hospital in the country to do so—a patient government program. Each ward has its own Patients' Administrative Group and officers who deal with problems at the ward level, such as the assignment of ward chores; selection of TV programs (to avoid domestic squabbles as to who will watch which program when); censuring certain patients for misbehavior; selection of the ward's Man of the Month (the "best all-around" patient, who receives a certificate and a prize); and other similar activities. The Patients' Administrative Council deals with similar problems on a service-wide basis. For this group three representatives are selected from each ward Group's officers to meet regularly with medical and supervisory personnel to discuss patient problems. Among the numerous activities of the PAC is the appointment of a committee to take newly admitted patients on a tour of the Pavilion to introduce them to the various facilities used in the treatment program.

The Recreation Division of the hospital sponsors an extensive program of activities including dances with female patients from other parts of the hospital, bridge games, and monthly smokers with speakers and entertainers from outside the hospital. An extensive athletic program is conducted in the new gymnasium and there is a 3½-acre amusement yard, complete with baseball diamond and bleachers; tennis, handball, and basketball courts; shuffleboard; and a fenced-off area of individual garden plots for horticulturally-minded patients.

Intensive individual therapy is not generally available in the John Howard Pavilion or elsewhere in the hospital. The doctor-patient ratio at St. Elizabeths is such that the medical staff has relatively little time available for individual treatment on a regularly scheduled basis. However, selected patients who are thought to require and be able to benefit from intensive individual treatment are taken for such treatment by doctors, either from the service or from other parts of the hospital, who have time available.

ADMISSION PROCEDURES

Pertinent information about the patient is gathered at the time of his admission, and he is assigned to the admission ward. On the same day he is examined by a doctor, who obtains from him a selective history, including his own version of his current legal difficulties. A psychiatric evaluation is made, a complete physical examination is done, and all the necessary additional studies—laboratory, X-ray, psychological, EEG, and other tests—are ordered. The patient is briefed by ward personnel as to available facilities and ward procedures. He is advised, among other things, that daily ward rounds are made by both the internist and a psychiatrist,

and that to see either or both, he must apply to the attendant in charge of the ward to have his name put on the appropriate roster.

Following an adequate period of observation, when all the necessary examinations have been made and all pertinent information regarding the patient's history (information from his family, abstracts from other hospitals and institutions, service record, etc.) is available, the patient is assigned to a resident psychiatrist for a "case study" and a time is set for him to appear at a staff conference. This conference is attended by the physicians on the service as well as other interested personnel, such as psychologists, social workers, hospital chaplains, and other professional people. Here the salient features of the patient's history are presented. The patient himself is interviewed and the necessary formulations are made concerning diagnosis and, where required, competency, mental condition at the time of the alleged offense, and causal connection between the illness and the offense. Further recommendations are made for treatment and management. Each doctor present voices his opinion on each of these questions, and the official hospital opinion reflects the majority opinion of the staff physicians. Only the doctors present formulate the final opinion, but the other personnel are free to enter into discussion of the case.

It should be emphasized that patients on the service are not indefinitely committed to maximum security. When, in the opinion of the psychiatrists, a patient has improved to the point where he is ready for increasing responsibility and will not constitute a management problem or an elopement risk, he may be recommended for transfer to an "outside" ward as a further step in his rehabilitation. From such a ward he may gain increasing privileges with progressively less direct supervision. Moreover, additional treatment facilities become available to him.

The general orientation in the John Howard Pavilion is therapeutic, rather than penal or simply custodial. The patient is treated as a patient, and the facilities of the service are directed toward his treatment and rehabilitation. Although the patients' legal problems demand a considerable portion of the doctors' time, they are of secondary importance in the program, which is aimed at helping rehabilitate the patients toward a useful and productive life in the community. •

Historical Highlights

A MYTH ABOUT PINEL

FOR OVER 150 YEARS, Philippe Pinel has been known—almost exclusively—as the French physician who, in the face of general opposition, singlehandedly unchained the insane. Familiar to many is Robert de Fleury's picture of Pinel striking a Napoleonic pose while a newly-liberated female kisses his hand in gratitude and other inmates in the background impatiently await their turn to be unshackled by the great humanitarian.

Pinel's great-nephew, René Semelaigne, fostered the myth of a wholesale liberation of patients with his circumstantial account of Pinel's actions upon being put in charge of Bicêtre. According to Semelaigne, Pinel, in his profound wisdom and benevolence, intuitively recognized the essential error in the use of chains and immediately approached the Revolutionary Government for permission to unshackle all his patients. An official named Couthon grudgingly and astonishedly granted this permission, and Pinel at once set about his program of reform, unshackling forty patients on the spot.

In actuality, Pinel's methods were not so heroic (nor so slapdash) as nineteenth-century accounts would have us believe. When he was appointed to Bicêtre in 1793, he had fifteen years of study and experience in psychiatry behind him. These years had shown him that complete physical restraint was a deterrent to recovery and that being such it had no place in therapy. He believed, moreover, that it was necessary to study the unfettered and untreated patient in order to gain thorough knowledge of the exact nature of his illness and from this knowledge to formulate a correct program of therapy. Consequently, when he had a hospital of his own, he initiated his concept of *"traitement moral"* in which restraint played only a minor part.

The abandonment of chains was a gradual process, however. It was a new step and not one to be taken hurriedly, especially when working with totally unpredictable patients, many of whom were actually homicidal. Pinel began by studying the case histories of all the patients. He then selected a few of the most promising and, one day, accompanied by several strong attendants, he ventured into the cells of these patients and ordered their chains removed and replaced with strait jackets. Experience demonstrated that patients thus released and restored to at least partial liberty responded well to other phases of therapy, and that it was in fact possible to grant them entire personal liberty within the asylum without endangering the general safety.

Although he could not complete his program in his two years at Bicêtre, Pinel was able in time to totally exclude chains from use in his next hospital, Salpêtrière. One should not infer, however, that he abandoned all methods of physical restraint and discipline in treating the insane. In his opinion, such controls were sometimes essential, both for the patient's immediate safety and for his eventual recovery, but in place of chains he preferred to use strait jackets, superior force, or confinement to a dark room, and to discard these restraints as soon as the patient became calm.

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CD-960

Have You Heard?

COMMUNITY: Parents of handicapped children in Marin County, Cal., can now call on specially trained sitters. About one year ago, more than 70 high school students answered the plea for help of Mr. Robert Foster, a teacher of the cerebral palsied at Sonoma State Hospital, and joined his instruction class. Many have completed the course and qualified as "*Handicappers.*" This program has been so successful that Mr. Foster now envisions a chapter of "Handicappers" in every Marin County high school. Because of the desire expressed by some participants to continue working with handicapped people, the present program will be extended to provide prevocational and precollege information and to encourage the young people to enter such professions as physical therapy, nursing, occupational therapy, and child welfare work.

CONSTRUCTION: A $200,000 rehabilitation center which will also contain recreational facilities is planned for the *Hospital for the Mentally Retarded* (M. A. Tarumianz, M.D., Supt.) at Stockley in Delaware. Funds for this project will come from proceeds from the Delaware All-Star High School football games of the past three years, from a donation by the Delaware Association for Retarded Children, from a Federal grant, and from anonymous private contributions.

The Psychiatric Institute for Children, the first of its kind in Ontario, was recently established in London by the Mental Health Division of the Ontario Department of Health. It is located in the Pratten Pavilion of the Beck Memorial Sanatorium. This property was purchased by the Province and will become available in its entirety when a new tuberculosis hospital is built by the London Health Association late in 1962. When renovations are complete, the Institute will have some 50 beds for short-term cases. Starting last February as an outpatient service, the institution, directed by Dr. D. E. Zarfas, was established primarily to meet the needs of the mentally retarded and to study the problems of mental retardation from the clinical and the research points of view.

Construction of nonprofit hospital, church, and educational facilities is likely to reach a new record in 1960. The forecast was made at the end of June by the *American Association of Fund-Raising Counsel.* It reported an increase of 19 per cent over the same period in 1959 (first five months) and reached a total of $847 million. New religious construction reached $381 million (9 per cent more than in 1959); private educational construction was $230 million (6 per cent increase); and private hospital construction hit $236 million (increase of 4 per cent). Based on the five-month reports, the Association indicated, new hospital construction may total $675 million this year, possibly making 1960 the greatest growth year in a decade. An estimated $300 million of total construction costs may be expected to come from private sources.

The J. N. Adam Memorial Hospital at Perrysburg, N. Y., a facility for the care of tubercular patients, will be converted to one for the care and treatment of the severely retarded. When the transformation is complete, the institution will be under the direction of Gowanda State Hospital and will be known as the *J. N. Adam State School Division* of Gowanda State Hospital.

GRANTS: In an effort to encourage greater numbers of young people to embrace the nursing profession, thus in time alleviating the manpower shortage, *Representative Kenneth A. Roberts* of Alabama introduced a bill in March, which would provide Federal grants of $200 a year to each student-nurse, with the condition that the states supplement these funds with amounts ranging from $50 to $100, depending upon the wealth of the individual state. The aid, limited to the financing of education, would be given only to schools licensed or approved by the state, and as far as possible, would be made available to all such schools within the state or locality.

The Division of General Medical Sciences of the National Institutes of Health has made a grant of $186,000 to *Western Reserve University,* Cleveland, Ohio, to support a broad program of research in aging. This is the third grant made to a university by the Public Health Service since 1957, to support large, comprehensive research programs on aging. The programs permit scientists from different fields to integrate their studies. The two earlier grants were to Duke University and the Albert Einstein College of Medicine.

The *American Contract Bridge League* has selected the National Association for Mental Health as the beneficiary of its 1960-61 charity program. It is anticipated that over $150,000, designated for the N.A.M.H. research program, will be raised through this A.C.B.L. activity. Each year, the A.C.B.L. Board of Directors selects an official league beneficiary. Past recipients have included the March of Dimes, the National Society for Crippled Children and Adults, the American Heart Association, the American Cancer Society, and others. Throughout the year, 3,000 affiliated league clubs in the U. S., Canada, Mexico, and overseas raise funds for the selected beneficiary through duplicate games and tournaments. All card fees are contributed to the charity program.

AWARDS: This year 138 psychiatric aides received the *National Association for Mental Health* awards for their services to the hospitalized mentally ill. The winners—78 women and 60 men—nominated from among 56,968 psychiatric aides by co-workers, patients, and visitors, represent a total patient population of well over 300,000 in 40 states and the District of Columbia.

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By RUTHANNA PENNY, R.N.
Superintendent of Nursing Services
and WILMA C. MITTLEBERG, M.A.
Food Administrator II
Porterville State Hospital, California

36
CAFETERIAS

How DO YOU FEED seventy severely retarded children cafeteria-style? How do you feed seventy to eighty infirm, bedridden, severely-to-moderately retarded patients most effectively, with only three to five employees on duty? What are the problems involved in instructing and training completely inexperienced personnel in the techniques of feeding not only spastic type children but severely retarded patients? These are problems constantly being faced by the staff at the Porterville State Hospital.

The dietary service at Porterville is rather unusual in a number of ways. This was the first institution in California to have a food service division staffed entirely with paid personnel. There are no congregate dining rooms; each ward has its own kitchen and dining room constructed for cafeteria service. Food is trucked to the wards in electrically heated food carts, which are plugged into the electrical socket provided in the ward kitchen. Nursing service employees take care of all the food-serving, dishwashing, and general clean-up of the kitchen and dining area. This includes mopping the floors—an absolute essential after every meal on a high-care ward.

The food service division has prepared four categories of diets for the various types of patients. The *general diet* is served to patients who are not restricted to special diets and who have no difficulty chewing or swallowing. An adaptation of this is the *chopped diet,* which is prepared for those children who have never learned to chew food. Also adapted from the general diet is the *nursery diet,* modified by pureeing all foods, and using less spices and condiments. (A special boon to the preparation of this diet has been the acquisition of a portable garbage disposal which takes the place of a more expensive blender.[1])

Special diets are ordered by ward physicians for those who require specific diets such as diabetic, ulcer, bland, low salt, diarrhea, and low calorie. Many employees have also devised various individual methods of preparing and servings foods to patients who otherwise would not eat. Special nourishments are made to comply with physician's orders. In all instances the temperature of the food is carefully controlled and checked before the meals are served to the children. Also there are public health aspects which must be considered. Utmost care must be taken in preparing and serving in order to prevent food contamination. The type and texture of many dishes is an ideal medium for growth of bacteria. This hazard is increased because of the long feeding periods necessary on many of the wards and also because the food must be cooled to a suitable temperature before the patients can tolerate it.

Of the hospital's average patient population of over 2500, ages 2-80 years, the majority (25 wards) are able to eat cafeteria style. The younger patients require considerably more assistance in carrying the trays, but are taught to sit at the table and to feed themselves. The dining room tables and chairs are scaled to the size of the individual. Patients from the ages of 5-6 years upward have been taught to pass by the cafeteria counter, pick up their trays, and seat themselves at the table, where their eating and behavior is supervised by employees. On the "high-care" wards, many of the patients have not yet acquired the more correct techniques of eating. They are taken to the dining room by groups, the more advanced going first. This has minimized the amount of dining room "clean-up" between groups.

On the contagious disease wards and in the acute hospital, trays are prepared in the ward kitchens and served to the individual patients by employees. Patients on the receiving ward are served cafeteria style in their own dining room.

THE INFIRM WARDS

The other eight wards of the hospital house more than 500 infirm patients. The dietary department has classified them as (a) feed selves with spoon, (b) feed selves with assistance, (c) must be fed by spoon, (d) bottle-feeding but are starting solid food, and (e) bottle-feeding only. All but the last two types are brought to the dining room in wheelchairs, by groups. The average time for feeding three meals per day on an infirm ward is six hours, with a minimum of thirty minutes to a maximum of an hour and a half for an individual child for one meal. Because of the time involved in getting patients prepared for meals and in and out of wheelchairs, there are days when some are left in bed for feeding because there are just not enough personnel to do the work. The employee who has "kitchen" duty prepares trays which are put on a cart for transporting to the

[1]*Ment. Hosp. 11:1:45 (Jan.) 1960.*

dormitory area. There, by careful organization and grouping of patients, one employee may feed two, three, or four patients, and perhaps supervise an industrial therapy patient, who has been carefully selected, in feeding another.

Since 1957, when the dietary service began this training system, a considerable number of the infirm patients have not only learned to feed themselves, but have also learned to ambulate to a degree which has permitted them to be transferred to other wards in the hospital. Some of the patients had never taken nourishment by any means other than a bottle, because they had never been taught otherwise, although some were in their teens. Even though it may take six months or longer to teach a child to eat from a spoon, the employees have a great sense of pride in achievement when this is accomplished.

Food itself can be measured only in calories and ounces but it would require more than a performance report to measure the patience and loving kindness of the employees who are striving daily to teach these patients to become more self-sufficient and better equipped to return to society. •

Spoon Fed

Ed. Note: The letter below was originally printed in Food Talks, *a bulletin of the Food Administration Section, Department of Mental Hygiene, California. It was sent to* Mental Hospitals *by Mrs. Margaret C. Madden, Chief Dietitian of the Philadelphia Psychiatric Hospital, Pennsylvania.*

Dear Sir:

Never "in all me born days" (and there have been a lot of them) have I run across a book of "manners" written especially for people who are mentally ill. Therefore, I would assume that "manners is manners" regardless of state of mind. There may be times when I am thinking about something else that I may forget to stand when an older person comes into a room, or fail to hold open a door at the proper moment, but when I sit down to eat I automatically butter bread with a knife (not the back of a spoon), eat spaghetti with a fork (not with a spoon), and use a knife to cut foods which cannot easily be cut with the side of a fork. Most of these motions are accomplished without any conscious thought on my part. They are almost reflex actions, because this is the way my elders taught me to handle food.

I've come full cycle, it seems. In my infant days I was handed a spoon and shown how to feed myself all sorts of gooey messes; as I grew older a fork was added to my collection, as more solid and recognizable bits of food were put on my plate. No knife yet, but the things that needed sectioning were all cut up by the eldest. Finally came the day when I was provided all three implements, and I was growing up.

Now the employee in the dining room implies that knives and forks are a hazard—not to me, but to him! There are many other things in the dining room that I can use if I really want to whack him but he apparently hasn't thought of this. Personally, I think he just doesn't want to go to the trouble of washing them. But they all go through a dishwashing machine. Maybe I am crazy; I just can't figure out his thinking processes. Anyway, all I get to eat with is a spoon, and with that I must eat not only gooey messes but solid things that defy spoon-cutting.

Or can he mean knives and forks are a hazard to me? But isn't everything in life a hazard? If I leaf through a magazine I face the hazard of cutting myself on the page edge and everyone knows paper cuts can be dangerous. Maybe I shouldn't sit in a chair because it might collapse, or take a bath because there might be a thunderstorm and everyone knows the tub is metal and water conducts electricity and there I am—electrocuted.

In my therapy sessions with that nice young psychologist who is so understanding of all the "psychological impacts" of life that have caused my present stage of confusion, he keeps stressing the fact that I must face reality. I wish it were possible to trade places with him for just one day and see how he would face the psychological impact of conquering a meal with only a spoon! I'll bet

he (as well as other employees) eats with the full complement of implements.

The other day in the patients' library I skimmed through the latest "book of manners" that I could find and it says that life has become more informal and that many of the old rules are not as rigidly upheld as they once were; but it still says that the old "irreducible minimum" with which a table should be set for the most informal meal is a "water glass, a napkin, and a fork, and knife at each place"—you see, they don't even mention a *spoon!* •

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Understanding Parents of Retarded Children

By KENNETH G. SUMMERSETT, M.S.W.
Director, Social Service Department
Newberry State Hospital
Michigan

IT IS DIFFICULT TO ASSESS ACCURATELY the extent of the ego damage and frustration which overwhelms parents when they are forced to face the fact that their child is mentally defective. Seldom are people asked to face a more frightening, bewildering, or threatening problem. Experienced professional people say that most parents react to the family tragedy thus: First, they feel sorry for themselves and wonder why it happened to them; second, they begin working to do what they can for their own child; and third, they work to do what they can for all retarded children. Or, in the words of Dr. William E. Kelley,[1] Assistant Director of the Michigan Department of Mental Health: "These parents inevitably will go through three phases of thinking and feeling in relation to the problem of retardation in their child. First, they fight it; then they fight with it; finally they fight for it."

Such parents with their combined strength, are often able to resolve apparently overwhelming problems. Some of the most successful group devices have been the "parent groups," which are "nonprofit, nonpolitical, nondiscriminatory groups for the parents, relatives, and friends of retarded children," to quote the bylaws of the Newberry Association for Retarded Children. Among the aims and purpose of such groups are:

1. To establish parent groups in every community in the state where there are mentally retarded children, and to advise and aid parents in the adjustment to their problems.
2. To encourage research, training, and education to the limit of the ability of the mentally retarded child.
3. To acquaint the general public with the seriousness of the problem and to promote a better understanding.
4. To further the advancement and training of personnel for work in the field of mental retardation.
5. To encourage legislation to provide adequate care and training at home, or in institutions, as a community responsibility.
6. To solicit and receive funds for the accomplishment of the above purposes.

[1]*Kelley, William E.: Span. I:II, 1957. Michigan Association for Retarded Children, Lansing, Mich.*

Parent groups are organized locally, work in immediate communities or counties, depending upon the density of the population, and are usually associated with the state home and training school or hospital in their geographical area. They are often affiliated on both the state and national levels, the national level being primarily concerned with the coordination of state groups and with the spearheading of a national approach to basic research and education.

A CREED WITH A PURPOSE

The Michigan Association for Retarded Children, like all such groups, holds that the mentally handicapped individual is, first of all, a person who has the same rights as his more fortunate fellow citizens. Because he is retarded, he is, in addition, entitled to some special consideration. It is this firm belief, coupled with the solidarity of sheer numbers, which does much to assist individual parents to transcend the turbulent psychological upheaval which results from the knowledge that their child is "different" and will always remain so. Working together and sharing their heartbreaking problems enables parents to progress through the three stages mentioned, to become able to resolve their conflicts. rechannel their drive "to deny existing reality," and thus become able to cope with their tragedy on a less overwhelming level.

Among the accomplishments of the Michigan group to date are:

1. The organization of some forty parents' groups throughout the state.
2. The provision of thousands of dollars worth of recreational, training, and educational equipment not provided by the state for institutionalized children.
3. The opening of the doors of state institutions to the public and to the parents.
4. The publication of a number of informational booklets about the mentally retarded, their needs, and their potentials.
5. Counseling with parents, helping them to realize that they are not alone in their trouble.
6. Cooperation with established state agencies in the study of mental retardation in Michigan.

On a concrete level, the members of parents' groups voluntarily contribute their own funds toward better equipment and facilities for the mentally retarded children in their state institutions. They have provided equipment and toys, television sets, phonographs and records, playground equipment, and other educational and recreational items. They have financed parties and entertainments for patients, and have purchased innumerable gifts for orphans and forgotten children.

THE WEIGHT OF NUMBERS

As volunteer groups, they have helped awaken the public conscience through educational releases, often, it is true, written for them by professional hospital staff members. But professional and state employees and organizations cannot dramatize the problems as can the afflicted parents themselves. Such releases from parent groups arouse the rest of the community to help find some of the needed solutions to the problems of the mentally retarded. Many of these problems can be solved only on a community level, and no one person, however capable, could do as much single-handedly. Still less could individual parents, usually unskilled and untrained in the problem area, hope to accomplish. Indeed, even a parent who is already professionally engaged in the field may well be emotionally blocked in his effectiveness to solve his own problem or to present it realistically for the consideration of others.

The alert hospital group worker will realize that it is the emotional support the group offers, rather than the tangible gifts it brings to the institution, which is its most important contribution. A parents' group serves as an organized resource for those who must face for the first time the problem of caring and planning for a mentally retarded child. It is often, indeed, the only group which other parents are initially "able to listen to" in planning for the best interests of their child and themselves. The worker who can learn from the group something of the parents' feelings toward their children, themselves, and the institution's policies and staff can become more effective in understanding the subtle conflicts which each parent brings to his problem-solving session.

THE BURDEN OF GUILT

Probably the worst problem which the worker will encounter during his early meetings with the parents is their terrible sense of guilt. This feeling may be accentuated by a mistaken religious attitude, and sometimes by the unfortunate coincidence that the retarded child was conceived on the false premise of welding together a marriage which was on the verge of collapse. More realistically, the parents are faced with the realization that this child may never be able to care for even his simple elementary needs, and that they, as a family, may not be able to care for him throughout his lifetime. They will be aware that he is not happy with normal children, that even his own siblings present unfair competition in all areas. They may not have the time or ability to train him in the minor things he may be able to master. These realizations emphasize some of the "guilt of incompleteness" with which they feel they have afflicted this child. This sense of "incompleteness" may be an ego-threatening experience, wherein the parents themselves feel incomplete as individuals, with the devastatingly concrete evidence of having produced a defective "incomplete" child. This sense of incompleteness may be resensitized in their feelings about the child because they are inadequate to meet his special needs. Thus the parents are under tremendous psychic duress, and in their efforts to seek relief from their unwarranted sense of guilt, they find themselves in a position which is emotionally untenable, and from which they cannot easily be extricated.

One of the initial important tasks, therefore, for the parents, is to achieve the psychic regeneration which is necessary to them for their very psychological existence. Group identification, group action, and group solidarity through membership in a parents' organization is one vehicle on which they may be able to ride back to some kind of homeostasis. Through the group process, there is the stimulation which accrues from group interaction, and some dilution of the sensitivity, guilt feelings, and overwhelming involvement that the parents of a retarded child suffer. No longer do they feel completely "set apart" from the rest of society because their child lacks the capacity to compete successfully, first with other children, and later, with the rest of the world.

MENTAL RETARDATION IS FOREVER

Once the parent has realized that life-long care will be a paramount need for the whole of the child's life, a tremendous conflict may develop. As Lydia C. Baker[1] writes, "The very nature of this problem precludes a satisfactory solution on the family level. Despite any poetic reference to the 'permanence' of a family, the family is at best rather an impermanent structure. Parents grow old and die, children grow and marry, or separate from their original family structure. . . . One of the saddest aspects of mental retardation is a permanent state of condition—the afflicted may be trained but not cured, and the cold fact remains that the family is not a sufficiently permanent structure to cope with the problem satisfactorily."

This is the point at which, if the parents are to survive psychologically, they must be helped to "fight for it"—the last step in adjustment mentioned by Dr. Kelley. Here again the parents' group may be the instrument of this final adjustment. The "community of parents" has done and can do much in the way of sponsoring research which will pay off before long in real preventive measures. These endeavors, as well as the gift-giving, the fund-raising, and the mutual support, provide meaningful outlets for the parents' emotions. In working through their feelings by positive constructive action, they will cease to be overwhelmed, and will gain security through doing something concrete. This group process in parents' organizations demonstrates the fact that "they serve themselves best who serve others." •

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[1]*Baker. Lydia C.: Mental Retardation, A Community Problem. Michigan Association for Retarded Children, Lansing, Mich.*

By PHILIP F. LERNER, M.D.
Head, Department of Neurology and Psychiatry
Lutheran and Mercy Hospitals
Baltimore, Maryland

The Former Patient: *A Potential Volunteer*

IT IS A WIDELY ACCEPTED FACT that the volunteer within the mental hospital is offering a definite contribution to the management, care, and treatment of the mentally ill. These volunteers come primarily from social-minded, progressive, service organizations such as ladies' auxiliaries, lay boards, or other interested groups. However, in recent years some medical people have developed an interest in another potential source—the ex-patient.

This writer believes that by recruiting the former patient, the hospital may bolster its volunteer program, especially since these ex-patients bring special aid to the therapy and management of the ill person. This was illustrated by Mrs. Isabel Schuman[1] of Spring Grove State Hospital, Maryland, in her article "Ex-patients Make Good Volunteers," in a recent issue of this magazine.

TWO-WAY HELP

There are basically two fundamental reasons for urging such recruitment. First, it is helpful to the ex-patient. Many of these people, by being able to act as volunteers, experience a type of therapy directed toward their personal maintenance and improvement of their mental or emotional state. Such a program can prepare them to resume their place in society, or train them to accept a new situation within the community. For example, some three years ago, in the Delaware (General) Hospital in Wilmington, one volunteer group initiated an unusual program. Mentally limited teen-age girls learned to perform a number of routine activities within the hospital. They served and fed incapacitated patients, assisted in promoting children's activities, helped with minor office work such as addressographing or mailing, and worked in the central supply division and the laundry. The program was designed primarily to offer these young girls practice and experience in activities which would prepare them for eventual outside employment. A recent article by Mrs. Marian B. Doom[2] reports the value and results of such a program.

The other basic reason why ex-patients should be considered for volunteer work is that they can contribute many skills, abilities, and talents. Often they have developed much more sympathy and understanding of patients' needs and interests than the volunteer who has never been afflicted by mental illness. Although the patients may not even be aware of the volunteer's previous illness, they somehow develop a more comfortable and secure feeling in the presence of this ex-patient, who brings them a view of the outside world, without pitying them. Of course, the other volunteers attempt to avoid, or even to conceal, such an attitude, but they frequently fail. Even professional entertainers or artists often experience such difficulties, despite their efforts to overcome them.

THE VOLUNTEER DIRECTOR

Certainly, volunteers in any hospital may present difficulties, and even cause some damage to both the patient and the volunteer, especially when ex-patients are involved. The improperly supervised, or poorly instructed volunteer can do more harm than good. Therefore, the volunteer program in any mental hospital should be under the supervision of a skilled director of volunteer services. This person should, of course, have adequate training and sufficient experience in selecting, training, and directing volunteer personnel, but further, she must be especially understanding of the nature of the ex-patient's illness and his needs and emotional "make-up." She should have the status of a department head, and be able to meet and discuss problems with other department heads in order to coordinate the activities of every area. To this end, a proper orientation program for volunteers should result in "picking the right man for the right job," and then utilizing his specific aptitudes and interests according to the needs and requests of the department heads. The volunteer service should have adequate space within the hospital, where the new volunteer can be interviewed in a relaxed uncrowded area, and where he may meet and discuss problems with his director or other department heads.

This writer realizes that objections to using ex-patients may be valid in some instances. Yet, there are a great number of people, who, when properly chosen and supervised, can and should be allowed to contribute part of their time, skills, and abilities to the mental hospital volunteer program, which today has become a specific therapy for the mentally and emotionally ill. •

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[1]*Schuman, Isabel: Ment. Hosp. 11:5:28-29 (May) 1960.*
[2]*Doom, Marian B.: An Experiment in Community Service, Hosp. 30:4:53-55 (Feb. 16) 1960.*

One of the participating experts instructs a patient in the proper method of applying cosmetics.

"THERAPY OF FASHION"

By THEO K. MILLER, M.D.,
Superintendent and Medical Director,
LEWIS G. CARPENTER, Ph.D.,
Clinical Psychologist,
and ROBERT B. BUCKEY, M.D.
Assistant Superintendent—Psychiatric,
Napa State Hospital, Imola, California

"THERAPY OF FASHION" was a pilot study recently completed at Napa State Hospital and was designed to recreate healthy feminine characteristics in a selected group of women patients. The study was sponsored by the San Francisco Association for Mental Health and carried out as a volunteer service project of The Fashion Group of San Francisco, Inc., the local branch of a national organization of key professionals in the fashion field. The project consisted of a series of three weekly classes attended by forty selected women patients in both the chronic and the acute categories.

The series began with a professional fashion show. Afterward, fashion experts advised individual patients about the type of clothes best suited to them. In subsequent sessions, the fashion experts gave demonstrations and instructions concerning correct facial make-up, hair styling, dress designing, proper foundation garments, and simple exercises to improve posture and develop poise. Leading San Francisco firms contributed cosmetic kits and dress fabrics for distribution among the participating patients.

With professional guidance, each patient was given the opportunity of designing a dress for herself and selecting the fabric and color combinations she liked best. Hospital personnel encouraged and assisted the patients to make their dresses. Two weeks after the classes were finished, twenty-six patients had completed their dresses. After a practice session in modeling they staged their own fashion show with the aid of the fashion experts before an audience of nearly 400 other women patients.

For some patients in the group, effects of the fashion project were dramatic and immediate. One woman in her early thirties had persistently refused to enter any socializing activities and had even been unwilling to use her privilege of going out on the grounds. She finally admitted that she was ashamed of her appearance and said that she never went to parties or dances because she "looked so terrible." After being fitted with proper foundation garments, she looked into a mirror and said, "My, I look so different." At the fashion show she went on stage clad in her new dress and looking confident and happy.

A patient from an acute ward felt the fashion project was the turning point of her illness. She reported enthusiastically that after one of the classes, "all at once the clouds rolled back, the sun was shining, and I felt like myself again." She left the hospital not long afterwards.

To provide more systematic and

Professional models display ensembles from one of San Francisco's exclusive apparel firms.

This woman is learning the art of graceful and relaxed walking from a professional model.

comprehensive information on the results of the project, participating patients and staff members filled out evaluation forms. Patients were asked: (1) whether they thought the project had helped them look "very much better," a "little better," or "no better," and (2) whether attendance at the classes had made them feel "much better," a "little better," or "no better." The staff filled out similar evaluation forms except that the variable "acting" was substituted for "feeling." A second evaluation with the same questions was made a month later.

One conclusion was immediately apparent. In both first and second evaluations of both chronic and acute patients, a large majority of patients and staff indicated they noticed some improvement. However the patients tended to downgrade their improvement on the second evaluation, especially in the "looking better" and "feeling better" categories. The shift, however, was not great enough to present a basically different pattern.

It is the combined opinion of the authors that fashion as a therapy may well prove to be an additional tool in the reactivation of women patients, especially among those in the chronic group with long-term periods of hospitalization. Also noteworthy were the stimulating effect this project had on other patients, and the interest displayed by the ward staff. News of what was transpiring spread rapidly and resulted in many requests from other patients to be included in a subsequent series of classes. There was also a noted improvement in their personal appearance.

The close contact and individual attention the patients received from these well groomed and cultured professionals—even for so short a period—have been morale builders themselves. The fact that they took time out from their busy lives and occupations for preparation, in addition to devoting four full days at the hospital to be of service, is sufficient proof to the patients that there are people outside the hospital who are genuinely interested in their welfare. •

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*Diamond, O. K.: New York J. Med. **59**:1792, 1959.

Rystan **Mount Vernon, N. Y.**

Intellectual Stimulation for Chronic Schizophrenics

By WILLIAM N. DEANE, Ph.D.
Staff Sociologist
Vermont State Hospital, Waterbury

A LECTURE SERIES with its speakers drawn about equally from the community and from the hospital is proving to be an effective tool in the rehabilitation of chronic schizophrenic patients at this institution. In addition, the exchange of information inherent in the series has contributed substantially to community education and to the hospital's relations with the people in its surrounding area.

From its start in May 1959,* through September 1960, the project has included a total of 62 speakers, with topics ranging from "A Governor's Typical Day" and "The Puerto Ricans in New York City" to a discussion of "Admission Procedures at the Hospital." For example, the Governor of Vermont outlined the duties of his office; the local fire chief explained the newer techniques of fire control; and a professor of sociology told about Puerto Rican problems in situations of culture conflict. On the hospital side of the ledger, the chiefs of service explained their duties: the supervisor of the admission service, for instance, described the commitment process, and the director of nursing service detailed her typical activities and responsibilities.

Meetings are held weekly, with one or more speakers participating at each session. Attendance is voluntary, and averages about 40 patients from the rehabilitation group of approximately 110, to which it is restricted.

A Lectureship Program Committee, consisting of 10 patients chosen by those in regular attendance from among their number, has the responsibility of selecting the speakers and their subjects. The project sociologist assists the committee in their selection when necessary, and often serves as liaison between the committee and the speakers. Usually the patient-group has definite choices as to topics and persons to present them; on some occasions, however, the committee is firm about a subject but, because of lack of knowledge or contact with the community, does not know of a proper speaker.

In these instances, and on the rare occasions when there are no spontaneous suggestions from the group, the project sociologist supplies names of speakers and possible topics. Acceptance of such suggestions is by a majority vote of the committee, as are all selections. It is interesting to note that the committee has so far rejected about half of the sociologist's suggestions, thus indicating a high degree of independence.

The reactions of the speakers to being invited to address a group of mental patients have been interesting and informative, as have their comments subsequent to their presentation. All but two individuals who have been asked to speak have accepted. Many have indicated surprise (and a certain pride) at having been selected, and most have shown some degree of apprehension, which makes their willingness to accept all the more remarkable.

Upon the conclusion of their talks, about one third of the speakers have made statements concerning the value of the program. Those who elaborated their views spoke in terms of "normalizing the hospital environment" and "giving the people outside an opportunity to better understand conditions within the hospital." One speaker referred to the program as "exciting"; another as "progressive."

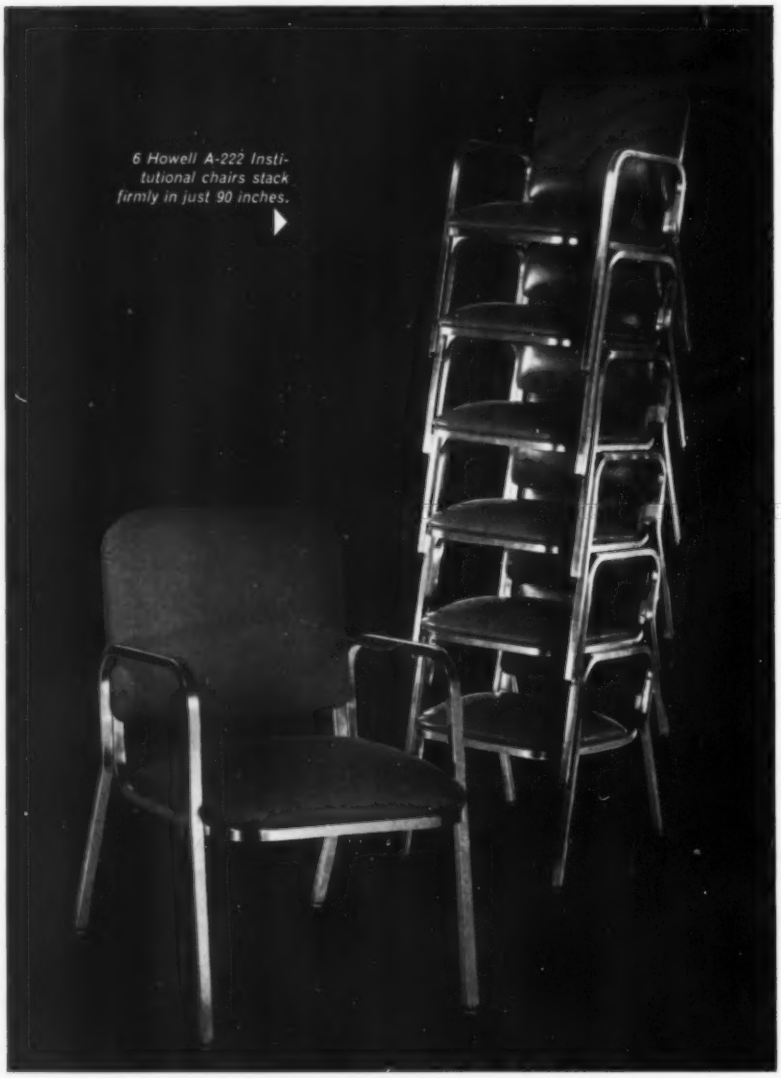
Some speakers commented extensively about the patients' questions during the discussion period. These comments were completely spontaneous and suggested that the patient group had responded in a way which the speakers had not anticipated. For example, one lecturer stated that he had never addressed a more perceptive audience than the patient group. Another, experienced in pedagogy and classroom procedure, said, "I wish my students would raise questions as perceptive and fertile as your patients do." A third speaker, who had anticipated a bad time, said with surprise, "Their questions were good ones. I didn't expect this. I thought that if they talked to me at all, it would be in a rambling way that I wouldn't understand. I thought they would be delusional and I thought they would make faces at me, but they didn't. They asked good, sensible questions the same as other people do."

"A WONDERFUL EXPERIENCE"

Other statements concerning the speakers' reactions to the participation in the program stressed their feeling of pride that the patients would wish to hear from them and that so many were on hand to hear them speak. One summed it up: "I was simply scared about this when thinking it over. I didn't know what to expect and I didn't know whether the group would be lethargic—unable to understand what I had to say—or silly, living in its own world. It was a wonderful experience for me to have done this and to discover how intelligent these people really are."

There is no need in this article to expound upon the value of education as a rehabilitation measure for mentally ill patients. This has already been well documented by David J. Vail, M.D., in his article, "Education as Therapy," in the March 1959 issue of MENTAL HOSPITALS; and by this author and Elizabeth M. Dodd in "Edu-

**The lecture series described herein was inaugurated as a part of the Vermont Project for the Rehabilitation of Chronic Schizophrenic Patients (Office of Vocational Rehabilitation, Special Projects Grant #180).*



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cational Techniques for the Rehabilitation of Chronic Schizophrenic Patients," in the February 1960 issue of the AMERICAN JOURNAL OF OCCUPATIONAL THERAPY. However, the lecture series has one or two specific beneficial aspects which bear reporting.

THE EDUCATED PATIENT

In the first place, it seems to be especially useful to the intelligent patient with considerable education. Generally speaking, this type of patient has not responded to the over-all rehabilitation program as well as have the patients of a lower level of education or intelligence, who constitute the majority, and for whom the program is therefore basically geared. The attendants who work closely with the patients resemble this latter group insofar as formal education and cultural factors are concerned. These conditions have made it possible for the attendants and the majority of our patients to get on well together. But the individual who differs radically from these norms, who, in short, may be more intelligent and better educated than the majority, and thus have different tastes, interests, and social status, is somewhat isolated. This type of patient finds the lecture series most appealing.

THE TEENAGER

There are also a few younger patients who do not respond well to the rehabilitation program—not necessarily because they are more intelligent, but because their interests differ from those of the majority, who are closer to middle age. The lecture series has been especially beneficial to these young people because it has given them an unusual opportunity to listen to informed, well-educated persons, to converse with them directly, and to ask questions of them.

This is not, of course, to say that the less well educated or less intelligent patients do not also benefit. It is only to point out that some of the educational and cultural vacuums which exist for the highly intelligent college individual and the teenager in the rehabilitation program are being compensated to a certain extent by the lecture series.

REVIEWS & COMMENTARY

FILM REVIEWS

COMMUNITY MENTAL HEALTH (black and white, 32 minutes) Produced for the Mental Health Film Board. Sponsored by the State Mental Health Authorities of California, Connecticut, Massachusetts, Pennsylvania, and Texas. Available from some State Mental Health Authority film libraries, or may be purchased from International Film Bureau, 57 East Jackson Blvd., Chicago 4, Illinois.

How does a community organize to provide a mental health service for its citizens? Obviously no single half-hour film could give a complete blueprint, but COMMUNITY MENTAL HEALTH does outline a possible approach—and does it in an effective and often emotionally moving way.

The approach is a Public Health one: the people of Kent, the film's "typical U.S.A. community," are as concerned with prevention as they are with treatment. Aroused to action by an incident of juvenile delinquency, the concerned citizens decide that many of their problems—crime, family break-up, divorce, and suicide—are associated with emotional disturbance, and they seek help from their State Community Mental Health Consultant. Together, they plan a mental health center which will not only serve individuals with problems but which will also reach out to other professional people and agencies to strengthen existing services. After forming a core committee, made up of the local health department, mental health association, press, professional people, civic leaders, and government officials, they get to work, although they experience many a set-back they eventually open their center's doors.

The balance of the film illustrates the services of the center in a series of dramatic episodes. The center's psychiatrist, psychologist, and social worker are shown handling cases, as well as consulting with other agencies in the community. These scenes are exceptionally well conceived and portrayed, although one might wonder how the center's staff found the time to do so much.

Some leading roles are played by professional actors (Eddie Albert is especially good as a newspaper editor who gradually becomes convinced of the center's value), but the large cast consists chiefly of amateurs who play roles similar to their real-life jobs. The writing, direction, and acting are above standard, and the net result is a satisfying and stimulating film. This very perfection may result in some members of the audience getting too rosy a picture of the way in which community mental health services are provided. The broad range of services offered by the small staff of the center in the film is certainly unrealistic. These are, however, minor drawbacks in view of the film's potential as an educational device to involve the public in community mental health programs. A film of this type would probably always be accompanied by a discussion leader who could point out that each community must tailor its mental health services to its peculiar needs. A discussion guide is provided for such resource persons.

COMMUNITY MENTAL HEALTH would be useful to a state mental health authority, mental health association, or mental hospital to develop citizen participation in community mental health services. Because it emphasizes the importance of coordinated efforts on the part of a cross-section of the community, it would also help college students—especially those planning to enter medicine, social work, or the ministry—to understand community organization on a practical level.

JACK NEHER
Mental Health Materials Center

BOOK REVIEWS

RECREATION AND PSYCHIATRY—Published by the National Recreation Association, 8 West 8th Street, New York 11, N. Y., 1960, 36 pages, $1.25.

This pamphlet includes papers presented by four prominent American psychiatrists, Drs. James S. Plant, William Menninger, Alexander Reid Martin, and Robert J. Campbell, on the subject of recreation.

The first paper was presented by Dr. Plant in 1937 in a pioneer effort to view recreation as a healthy framework for the American way of life in mid-century. Unfortunately, Dr. Plant's dreams are still far from being realized. Recreation is still considered a "frill" in our institutional structure, and a slightly immoral addendum which is often the first to be cut when budget appropriations drop. The puritanic tradition of the evils of play, and even enjoyment, dies hard in the American conscience!

Dr. Martin, chairman of the American Psychiatric Association's Committee on Cooperation with Leisure-time Agencies, combines his extensive knowledge of human maladjustment with a deep interest in recreation, to give a thoughtful resume of recreation's role in preventive medicine.

Drs. Menninger and Campbell discuss the various clinical applications of recreation. Dr. Campbell makes a plea for imaginative application of recreation programs as therapeutic tools in our ever-expanding psychiatric outpatient departments and clinics.

This is a delightful and stimulating pamphlet which should be helpful in planning for better patient care. It might even promote insight into our own personal use of leisure time for recreation.

ROBERT H. BARNES, M.D.

REPORT ON REMOTIVATION—By the Remotivation Project Advisory Committee, Mental Hospital Service, American Psychiatric Association, 37 pages.

Since 1956, when the Remotivation Technique was first introduced into the Philadelphia State Hospital, personnel from 150 hospitals have attended Remotivation training courses in 33 mental hospitals. The aide-training course requires 15 to 30 hours of instruction and the project is supported by the Smith Kline & French Foundation.

In 1959, a "follow-up" team visited 13 mental hospitals using this technique, to determine if Remotivation had been generally accepted, and how it could be expanded and strengthened in the future. The "Report on Remotivation" presents briefly the findings of the team and describes the technique itself.

The team reported a considerable degree of success of the program in the hospitals it visited. The interest and support of the hospital administration were found to be key factors in development, and the services of a full-time coordinator for the program were helpful.

The pamphlet describes in detail the organization and operation of the Remotivation Program, which aims to "remotivate patients to take a renewed interest in their surroundings and encourage the psychiatric aide to take a more personal interest in his patients." The basis of the program is a series of regularly scheduled meetings between the aide and a small group of patients to discuss current events or topics of general interest.

The report, which is easily read, and illustrated with photographs, can be obtained from the A.P.A. Mental Hospital Service, SKF Remotivation Project, Box 7929, Philadelphia 1, Pennsylvania.

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*Stieglitz, E. J., in Handbook of Nutrition, ed. 2, New York, Blakiston, 1951, p. 337.

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**Abraham, W., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, p. 132.*

Literature supplying details of dosage and administration available on request.

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NEWS & NOTES

Remotivation Training Expanded

Remotivation, a program to bridge the gap between the half-world of the mentally ill and the real world outside the hospital, has been expanded with the establishment of two new regional training centers.

The establishment of these centers to train psychiatric aides and nurses in Remotivation techniques was recently announced by Robert S. Garber, M.D., of New Jersey, chairman of the A.P.A.-Smith Kline and French Foundation Remotivation Project.

The centers are located at Central State Hospital in Oklahoma and Western State Hospital in Virginia. Other regional training centers are planned to cover the nation. The expansion, like the original program, is supported by funds from the Smith Kline and French Foundation, Philadelphia.

Staffs at the training centers will instruct aides and nurses from other mental hospitals in the area. Classes will be arranged periodically to conform to the needs of each section. Yearly workshops for Remotivation workers are planned in each of the area training centers.

A Special Mailing

Thanks to the generosity of the Division Fund of Chicago, the Mental Hospital Service subscribers will receive this month an extra mailing, the GAP Report No. 46, "Administration of the Public Psychiatric Hospital." It was sent out at the same time as the October issue of MENTAL HOSPITALS.

Seminars of Psychiatry for GP's

The third series of seminars of psychiatry for the general practitioner started on September 14 at the Carrier Clinic, Belle Mead, N. J. Scheduled on a once-a-week basis through October 26, this series is sponsored by the N. J. Chapter of the American Academy of General Practice, the Special Committee on Mental Health of the Medical Society of New

QUARTERLY HOSPITAL PROFESSIONAL CALENDAR

A.P.A. ANNUAL MEETINGS:

1961 May 8-12, Hotel Morrison, Chicago, Ill. (117th)
1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 13-17, Ambassador Hotel, Los Angeles, Cal. (119th)

A.P.A. MENTAL HOSPITAL INSTITUTES:

1960 Oct. 17-20, Hotel Utah, Salt Lake City (12th)
1961 Oct. 16-19, Hotel Sheraton-Fontenelle, Omaha, Neb. (13th)
1962 Sept. 24-27, Hotel Americana, Miami Beach, Fla. (14th)

OTHER A.P.A. MEETINGS

A.P.A. Regional Research Conference—Content of Psychiatric Research under State, Federal, and Community Sponsorship, *October 12-13*, Mayo Clinic, Rochester, Minn.

A.P.A. Committee Meetings, *October 28-29*, A.P.A. Central Office, Washington, D. C.

A.P.A. Council Meeting, *December 2-3*, A.P.A. Central Office Washington, D. C.

OTHER PROFESSIONAL ORGANIZATIONS

THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, *October 16-17*, Hotel Utah, Salt Lake City.

VOLUNTEER SERVICE COORDINATORS, *October 16-17*, Hotel Utah, Salt Lake City.

AMERICAN SOCIETY OF MENTAL HOSPITAL BUSINESS ADMINISTRATORS, Annual Meeting, *October 17*, Hotel Utah, Salt Lake City.

PSYCHIATRIC NURSES, *October 17*, Hotel Utah, Salt Lake City.

HOSPITAL COMMITTEE, WESTERN MENTAL HEALTH COUNCIL ON TRAINING AND RESEARCH, Dinner Meeting, *October 19*, Hotel Utah, Salt Lake City.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS, Annual Meeting, *October 26-28*, Jack Tar Hotel, San Francisco, Cal. (Inq. Mack I. Shanholtz, M.D., State Office Bldg., Richmond, Va.)

AMERICAN PUBLIC HEALTH ASSOCIATION, Annual Meeting, *October 31-November 4*, Civic Auditorium, San Francisco, Cal.

GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, Regular Meeting, *November 3-6*, Asbury Park, N. J. (Inq. M. J. Farrell, M.D., Box C, Waverly 78, Mass.)

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Annual Conference, *November 14-18*, Statler-Hilton Hotel, Los Angeles, Cal.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, Annual Meeting, November *17-19*, Denver-Hilton Hotel, Denver, Colo.

COUNCIL ON MENTAL HEALTH OF THE A.M.A., Annual Conference of Mental Health Representatives of State Medical Associations, *November 18-19*, (Inq. R. J. Plunkett, M.D., A.M.A. Council on Mental Health, 535 N. Dearborn, St., Chicago, Ill.)

ACADEMY OF RELIGION AND MENTAL HEALTH, Annual Symposium, *November 18-20*, Arden House, Harriman, N. Y. (Inq. Harry Meserve, Program Director, 16 E. 34th St., New York 16, N. Y.

ASSOCIATION FOR RESEARCH IN NERVOUS & MENTAL DISEASE, Annual Meeting, *December 9-10* (Inq. R. J. Masselink, M.D., 700 W. 168 St., New York City.

Jersey, the N. J. Neuro-Psychiatric Institute at Princeton, and the Carrier Clinic. A faculty of outstanding psychiatrists, one neurologist, and one specialist in obstetrics and gynecology will cover a variety of subjects of particular interest to general practitioners. Topics include: "Hypnosis and the Physician," "School Phobias," "Psychosomatic Aspects of Obstetrics and Gynecology," "Hormones and Behavior," "Whiplash Injuries and the Psychiatric Implications," among others.

Scheduled speakers are: Walter E. Barton, M.D., Boston University; Herbert S. Gaskill, M.D., University of Colorado; M. Royden C. Astley, M.D., University of Pittsburgh; J. Franklin Robinson, M.D., Wilkes-Barre General Hospital, Pa.; John Donnelly, M.D., Yale University; Edward C. Mann, M.D., Cornell University; Cecil Wittson, M.D., University of Nebraska; Leo Madow, M.D., Women's Hospital, Philadelphia, Pa.; Jules Masserman, M.D., Northwestern University; Howard P. Rome, M.D., University of Minnesota Graduate School; Harold Rosen, M.D., Johns Hopkins University; and C. Knight Aldrich, M.D., University of Chicago.

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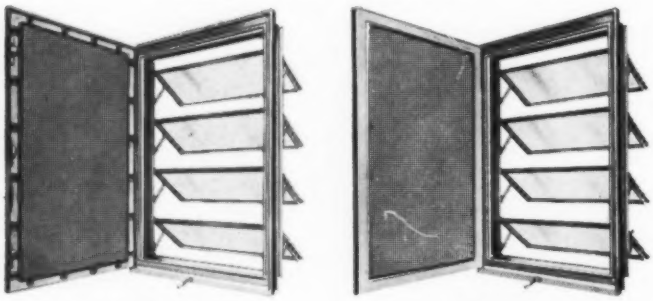

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A Reminder: SKF Fellowships

The A.P.A.-Smith Kline & French Foundation Committee will meet on October 30, 1960, to consider applications for fellowships. Institutions interested in obtaining grants for medical students working either during summer months or on a part-time basis; for lectureships; or for staff training are reminded that the deadline for submitting applications is drawing near. Application forms can be obtained from: SKF Foundation Fellowship Committee, American Psychiatric Association, 1700 18th Street, N.W., Washington 9, D. C.

PEOPLE & PLACES

MINNESOTA: **Dr. David J. Vail,** acting director of the Minnesota Department of Public Welfare since the end of January, became the medical director on August 1.

Dr. Ralph S. Methany, Manager of the VA Hospital, Boston, Mass., has been named area medical director for the Veterans Administration at St. Paul, Minn., replacing Dr. Oreon K. Timm.

OHIO: **Dr. Wendell A. Butcher** resigned as assistant commissioner of mental hygiene and head of the Bureau of Mental Deficiency to devote full time to the private practice of psychiatry.

Dr. Roger M. Gove, superintendent of Columbus State School, is the new head of the Ohio Psychiatric Association.

Dr. Jerry O. Crist, a staff physician at Toledo State Hospital for the past six years, has accepted a temporary appointment as acting superintendent of Lima State Hospital for the Criminally Insane.

Dr. Gordon R. Loomis was named superintendent of the Sagamore Hills Children's Psychiatric Hospital, now under construction and scheduled to open early next year.

Miss Esther Wagner, director of the social service department at Cleveland Psychiatric Institute and Hospital was honored by the National Association of Social Workers, Cleveland Area Chapter. She received an award "in recognition of her example of dedicated and inspiring services in her capacity of director of social service at the Cleve-

land Psychiatric Institute and Hospital. As a pioneer in demonstrating the high quality of service that professional social workers can render in mental hospitals, Miss Wagner has provided consistent leadership in the achievement of higher standards of service, better professional salaries, and increased community understanding of the needs of the mentally ill. . . ."

HERE & THERE: **Dr. Russell N. Carrier,** president of the Carrier Clinic, Belle Mead, N. J., and **Dr. Robert S. Garber,** medical director, have been appointed to the medical staff of Temple University School of Medicine, Philadelphia, Pa., as associate professors of psychiatry.

Dr. Arthur P. Holstein is now director of St. Clair Hospital, Detroit, Mich. Prior to this appointment, he was on the psychiatric staff of the VA Hospital in Ann Arbor, Mich.

Dr. Leonard Cammer has resigned as medical director of Gracie Square Hospital in New York City.

Mr. Cyril Greenland, who was chief psychiatric social worker at the Ontario Hospital at Whitby, is now social work advisor for the Mental Health Division, Provincial Department of Health, and consultant in psychiatric social work and chief of social services at Toronto Psychiatric Hospital.

Dr. David C. Wilson, formerly of the University of Virginia Hospital, Charlottesville, has moved to Imola, Cal., where he is now director of professional education at Napa State Hospital.

Mr. Fred P. Ryder has been appointed administrator, Anclote Manor Hospital, Tarpon Springs, Fla. He was formerly hospital consultant for the Florida State Board of Health.

Dr. Christian Kole became superintendent of Winfield, (Kan.) State Hospital and Training School in July. He replaced **Dr. Franklin R. Miller,** who resigned to become associate professor of medicine at Hahnemann Medical College in Philadelphia, Pa.

Mr. Stephen J. Cornett, Jr. has been appointed industrial therapy consultant for the Kentucky Department of Mental Health. In addition to his new responsibility to give consultation services to the other three hospitals, he will continue to supervise the industrial therapy department and the rehabilitation program at Eastern State Hospital in Lexington, where he has been the industrial therapist for five years.

The new manager of the Veterans Administration Hospital at Bedford, Mass., is **Dr. Salvatore P. LaCerva** who comes from the VA Hospital at Perry Point, Md., where he had been serving as director of professional services.

Dr. Harold B. Witten has replaced **Dr. Wayne J. Boyd** as superintendent of Western State Hospital, Ft. Supply, Okla. Dr. Boyd has moved to Eastern State Hospital in Vinita.

Dr. Ralph H. Kuhns, a psychiatrist with the VA Regional Office in Chicago, Ill., has been appointed by the U. S. Chess Federation to coordinate the introduction of chess in the state mental hospitals as a therapeutic measure following its success in Germany and Great Britain. Dr. Kuhns, a third-generation chess enthusiast, is a member of the Central Y.M.C.A. Chess Club in Chicago. He has also written extensively about the game.

Dr. Frank H. Luton is the new clinical director at the Central State Hospital, Nashville, Tenn.

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1. Kovitz, B.: Management of Psychotic Tension Symptoms with Trifluoperazine: A Preliminary Report, in *Trifluoperazine: Clinical and Pharmacological Aspects*, Philadelphia, Lea & Febiger, 1958, pp. 144-149.
2. Brooks, G.W.: Definite Ataractic Therapy in the Rehabilitation of Chronic Schizophrenic Patients: A Preliminary Report on the Use of Trifluoperazine, *ibid.*, pp. 54-61.

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